

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
OF THE GROUP HEALTH CARE PLAN
FOR THE EMPLOYEES OF
JACKSON COUNTY GOVERNMENT**

EFFECTIVE: DECEMBER 1, 2012

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THE VALUE OF YOUR HEALTH BENEFIT PLAN

This document is a description of the **JACKSON COUNTY GOVERNMENT Group Health Benefit Plan** (the Plan). No oral interpretations can change this Plan.

This Group Health Plan believes this Plan is a “Grandfathered Health Plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a Plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the contact information listed in the General Plan Information Section. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This Health Benefit Plan provides you and your family with important protection against financial hardship that often accompanies illness or injury. It has been carefully designed to provide excellent medical, dental, and vision benefits and offers financial incentives if you seek the most efficient quality health care services available. The Company provides the Health Benefit Plan for you and your family.

Coverage under the Plan will take effect for you and your eligible Dependents when you and such Dependents satisfy the waiting period and all eligibility requirements of the Plan.

The Company fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co- payments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination. This document summarizes the Plan rights and benefits for covered Employees and their Dependents, explaining:

- ♦ How you become eligible to participate,
- ♦ What benefits are available to you and your family, and
- ♦ How the Plan is administered.

We hope you'll take the time to review your benefit coverage from **JACKSON COUNTY GOVERNMENT** and share with your family ways to do your part to make the health care system work cost effectively and efficiently for you.

Please contact your Human Resources Department and/or Claims Administrator should you have any questions regarding your Plan.

SCHEDULE OF BENEFITS

DEDUCTIBLE/OUT-OF-POCKET/PENALTIES			
SUMMARY OF	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Mandatory Hospital Pre-Admission And Pre-Surgical Review Refer To The Section below and the section Entitled “Utilization Review Program”			
Non-Compliance Penalty	50% Up to \$1,000		
	See list of services subject to Penalty in Utilization Review Section		
Lifetime Maximum Benefit	Unlimited		
Annual Maximum	\$5,000,000		
Calendar Year Deductible			
Individual	\$1,000		
Family	\$3,000		
Note: The Family Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined.			
Out-of-Pocket Maximum (in excess of Deductible)			
Individual	\$1,000		\$3,000
Family	\$3,000		\$6,000
Note: The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined.			
Tier I, Tier II and Tier III expenses will be applied equally toward the satisfaction of both the Tier I, Tier II and Tier III Out -of-Pocket Maximums.			
Co-payments continue to be the responsibility of the Covered Person.			

Prior to receiving treatment for any of the services listed below, please contact the Utilization Review Manager as shown on your ID card. You must call at least 72 hours prior to an elective procedure or admission and no later than 72 hours after an emergency procedure or admission. Failure to obtain pre-certification may result in a reduction of benefits as stated above.

- All Hospitalizations
- Transplant Services (including transplant evaluation)
- Inpatient Rehabilitation Facility Stays
- All Substance Abuse Treatment
- All Mental Disorder Treatment
- Skilled Nursing Facility Stays
- Home Health Care
- Hospice Care
- Physical Therapy (PT)
- Dialysis
- Speech Therapy (ST)
- Occupational Therapy (OT)
- Cardiac Rehabilitation Therapy
- Outpatient Surgery
- Chemotherapy & Radiation Therapy
- Durable Medical Equipment Costing Over \$500
- Pre-natal and Maternity Care
- MRI & CT Scans

SPECIAL COVERAGES

Refer to Specific Section for Details

SUMMARY OF SERVICES	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Second Surgical Opinion “ When Required By Utilization Review ”.	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Preventive Care, including, but not limited to: routine office visits and related laboratory charges, immunizations*, school and sport physicals and TB skin tests. (NOTE: also see below for separate routine preventive benefits.) *Flu shots are covered ONLY when administered at Jackson County Health Department.	100% after \$20 co-pay – Preventive Care services shown to the left are subject to \$300 maximum benefit payable. Once \$300 is met, remaining charges apply to deductible and co-insurance. \$300 maximum does not apply to Routine Pap Smear (and related charges), Routine PSA (and related charges), Routine Colorectal Cancer Screening (and related charges), and Mammograms (and related charges)		60% Deductible Applies
Routine Pap Smear, related exam and charges	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Routine PSA, related exam and charges, age 40 and older	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Routine Colorectal Cancer Screening , related exam and charges, age 50 and older	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
All Mammogram, Breast Ultrasound, related exam and charges	100% No Deductible	100% No Deductible	100% No Deductible
	<p style="text-align: center;"><i>A baseline mammogram for women age 35 -39 years of age</i> <i>An annual mammogram for women age 40 and older</i> <i>A mammogram at the age and intervals considered Medically Necessary by the woman’s health care provider for women under age 40 and having a family history of breast cancer, prior personal history of breast cancer or other risk factors.</i></p>		
Wigs due to Chemotherapy/Radiation Therapy	90% Deductible Applies		60% Deductible Applies
	Wigs Lifetime Maximum - \$500		
Diabetic Self-Management Training	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
	<p style="text-align: center;"><i>Diabetes Self-Management Training limited to 3 visits after the initial diagnosis Limited to 2 visits after a change in the condition.</i></p>		
Charges for the diagnosis and treatment of Autism Spectrum Disorder	Benefits are based on place/type of service	Benefits are based on place/type of service	Benefits are based on place/type of service
Transplant Travel Expenses Only	<p style="text-align: center;">100% No Deductible <i>Lifetime maximum of \$10,000 for the patient and one travel companion (refer to the transplant travel section of the policy)</i></p>		

PHYSICIAN AND OFFICE SERVICES

SUMMARY OF SERVICES	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Office Visits	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Surgeon	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Diagnostic X-Ray & Lab – <i>with or without office visit charge</i>	100% No Deductible	100% No Deductible	60% Deductible Applies
Independent Lab, Radiologist & Pathologist	100% No Deductible	100% No Deductible	*60% Deductible Applies
<i>*Services performed by a Tier III Provider which the patient did not have the option to choose, which relate to Tier I/Tier II Services will be payable at the Tier I/Tier II rate.</i>			
Allergy Injections	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Allergy Testing	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Chemotherapy	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Occupational & Speech Therapy	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Physical Therapy (including preventive physical therapy for multiple sclerosis)	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies maximum benefit paid \$20 per visit
Physical Therapy Calendar Year Maximum – 24 Visits			
Chiropractic Services			
Office Visits	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Manipulations/Physical Therapy	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
X-Rays	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Chiropractic Calendar Year Maximum – 10 Visits for all services combined			
Podiatric Services			
Office Visits	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies
Surgery	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
X-Ray & Lab	100% No Deductible	100% No Deductible	60% Deductible Applies
Orthotics	Not Covered	Not Covered	Not Covered
Infertility Services			
Initial Diagnostic Testing	Benefits are based on the place of service	Benefits are based on the place of service	Benefits are based on the place of service
Infertility Treatment	Benefits are based on the place of service	Benefits are based on the place of service	Benefits are based on the place of service
TMJ Care	No Coverage	No Coverage	No Coverage
Other Covered Services	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

SUMMARY OF SERVICES	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Emergency Room			
Emergency	100% After \$50 Co-pay	100% After \$50 Co-pay	100% After \$50 Co-pay
Non-Emergency	100% After \$50 Co-pay	100% After \$50 Co-pay	100% After \$50 Co-pay
Diagnostic X-Ray & Lab	100% No Deductible	100% No Deductible	60% Deductible Applies
Pre-Admission Testing	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Surgeon	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Occupational & Speech Therapy	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Physical Therapy (including preventive physical therapy for multiple sclerosis)	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies maximum benefit paid \$20 per visit
Physical Therapy Calendar Year Maximum – 24 Visits			
Chemotherapy & Radiation Therapy	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician	90% Deductible Applies	90% Deductible Applies	*60% Deductible Applies
*Services performed by a Tier III Provider which the patient did not have the option to choose, which relate To Tier I/Tier II Services will be payable at the Tier I/Tier II rate.			
Other Covered Services	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies

INPATIENT HOSPITAL

SUMMARY OF SERVICES	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Facility	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Room, Board & Miscellaneous	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Nursery	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Baby & Mother's Charges Will Be Combined			
Diagnostic X-Ray & Lab	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Surgeon	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Physician Visits	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Private Duty Nursing	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	90% Deductible Applies	90% Deductible Applies	*60% Deductible Applies
*Services performed by a Tier III Provider which the patient did not have the option to choose, which relate To Tier I/Tier II Services will be payable at the Tier I/Tier II rate.			
Other Covered Services	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies

OTHER COVERED SERVICES

SUMMARY OF	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Extended Care Facility	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Extended Care Facility Convalescent Period Maximum – 100 Days</i>			
Home Health Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Home Health Care Calendar Year Maximum – 100 Visits</i>			
Hospice Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Bereavement Counseling	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Bereavement Counseling Individual Maximum – \$200</i>			
Social Services	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Social Services Lifetime Maximum - \$300</i>			
Respite Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Respite Care Limited to 5 days in any 30 day period</i>			
Ambulance	90% Tier I/Tier II Deductible and Out-of-Pocket Applies. NOTE: When the Jackson County Ambulance service is used, 100% after a \$100 co-pay		
Durable Medical Equipment	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Limited to the lesser of the purchase price or the total anticipated rental charges</i>			
Prosthetic Appliances	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
<i>Includes replacements which are medically necessary or required by pathological change or normal growth</i>			

PSYCHIATRIC & SUBSTANCE ABUSE CARE

SUMMARY OF SERVICES	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Inpatient Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Outpatient Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Physician Visits	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies

SERIOUS PSYCHIATRIC CARE

SUMMARY OF	TIER I PROVIDERS	TIER II PROVIDERS	TIER III PROVIDERS
Inpatient Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Outpatient Care	90% Deductible Applies	90% Deductible Applies	60% Deductible Applies
Physician Visits	100% After \$20 Co-pay	100% After \$20 Co-pay	60% Deductible Applies

Remember, certain services require pre-certification through Utilization Review Management. Please refer to the Utilization Review Section of the Document for further details or see the back of your I.D. Card.

Expenses Related To Satisfaction Of The Individual Or Family Deductibles, Per Visit Co-payments, Prescription Drug Co-payments, Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The Tier I/Tier II and Tier III Level Of Benefits.

PRESCRIPTION DRUG PLAN

RETAIL PRESCRIPTION PLAN	
If obtained through the Prescription Drug Plan – 100% after satisfaction of applicable co-payment: - Per 30 day supply	
Generic	\$10
Formulary Brand	25% not less than \$25 or more than \$50
Non-Formulary Brand	25% not less than \$40 or more than \$100
MAIL ORDER PRESCRIPTION PLAN	
If obtained through the Mail Order Prescription Drug Plan – 100% after satisfaction of applicable co-payment: - Per 90 day supply	
Generic	\$20
Formulary Brand	25% not less than \$50 or more than \$100
Non-Formulary Brand	25% not less than \$80 or more than \$200
PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS	75% After the appropriate co-pay. Does not apply to the Out-of-Pocket Maximum.
COVERAGE INCLUDES	COVERAGE EXCLUDES
<ul style="list-style-type: none"> ♦ Federal Legend Drugs ♦ AIDS Medications ♦ Insulin ♦ Diabetic Supplies ♦ Needles & Syringes ♦ Imitrex, vial & autoinjector (48 kits per year) ♦ Dexedrine to age 25 ♦ Prenatal Vitamins ♦ Accutane to age 25 ♦ Genetically Engineered Drugs ♦ Injectables ♦ Bee Sting Kits ♦ Contraceptives, including the patch, depo provera, injectables ♦ RhoGAM 	<ul style="list-style-type: none"> ♦ Growth Hormone ♦ Diagnostic Agents ♦ Rogaine ♦ Devices ♦ Smoking Cessation Products ♦ Vaccinations ♦ Anorexiant, Diet Drugs ♦ Life Style Drugs ♦ OTC Counterparts ♦ Cosmetic Drugs ♦ Injectable Fertility ♦ Fertility Drugs ♦ Vitamins ♦ Children's Vitamins

Expenses Related To Satisfaction Of The Individual Or Family Deductibles, Per Visit Co-payments, Prescription Drug Co-payments, Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The Tier I/Tier II and Tier III Level Of Benefits.

DENTAL SCHEDULE OF BENEFITS (Optional)

Calendar Year Maximum Benefit For Preventive, Basic and Major Services	\$1,500
Calendar Year Deductible	
Individual	\$50
Family	\$150
<i>For Basic and Major Services. The Deductible does not apply to Preventive and Orthodontic Services .</i>	
Note: The Family Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined.	
Co-Insurance Factor	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontia*	
Deductible	N/A
Co-Insurance	50%
Lifetime Maximum	\$1,500
*Limited to Dependent Children under age 19	

VISION SCHEDULE OF BENEFITS (Optional)

CALENDAR YEAR MAXIMUM-ALL SERVICES	\$200
VISION EXAMINATION	100% After \$20 Co-Pay
LENSES	100% After \$20 Co-Pay
FRAMES	100% After \$20 Co-Pay

PLAN PARTICIPATION

You must enroll for coverage under this Plan by obtaining an enrollment form from the Human Resources Department. Complete the form in full, sign and return it promptly to the Human Resources Department.

ELIGIBLE EMPLOYEES

All full-time employees who are regularly scheduled to work at least 30 hours per week (and other eligible members as determined by the County Board).

Employees who have retired in accordance with the provisions of the County's retiree health insurance program or in accordance with the provisions of the Illinois Municipal Retirement Fund (IMRF).

Retirees – any coverage shown in the Schedule of Benefits you may have during retirement will be continued provided required contributions are made.

WHEN EMPLOYEES BECOME ELIGIBLE

WAITING PERIOD

A “*Waiting Period*” is the time between the first day of employment and the first day of coverage under the Plan. The waiting period is counted in the Pre-Existing Condition Limitation time.

ENROLLMENT DATE

The “*Enrollment Date*” is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Nursing Home Employees--are eligible for coverage on the first of the month following six (6) months of full-time employment.

Nursing Home Supervisors--are eligible for coverage on the first day of the month following date of hire. All Other Employees--are eligible for coverage on the first day of the month following date of hire.

If you return from a leave of absence which qualifies under the Family and Medical Leave Act (FMLA) or the Victims' Economic Security and Safety Leave (VESSA) and you chose not to retain health coverage under this Plan during such leave, your coverage will be reinstated upon return from such leave, without any waiting period if you previously satisfied any applicable waiting period.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Your coverage begins on the date on which you become eligible for Plan benefits provided you have completed an enrollment form and make any required contributions.

If you apply for coverage on or before your eligibility date, or within thirty-one (31) days after your original enrollment date, your coverage will begin on your original eligibility date.

If you terminate your employment, for any reason, during your eligibility waiting period and are subsequently re-employed, you must complete the same eligibility waiting period as applied to a new employee. This requirement applies to both you and your eligible dependents.

LATE ENROLLMENT

“Late Enrollee” means an individual who enrolls under the Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

If you do not apply for coverage within thirty-one (31) days of the date you become eligible, or during a Special Enrollment Period, or if you previously elected to end your coverage in the Plan, you may apply for coverage during the annual enrollment period in November and the effective date of coverage will be December 1st, or at any time and the effective date of coverage will be six (6) months following the date you complete an enrollment form and make any required contributions; you will be subject to the Pre-Existing Conditions Limitations for Late Enrollees.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage as a Late Enrollee is not treated as a waiting period and therefore, is not counted in the Pre-Existing Condition Limitation time.

EMPLOYEES WHO ARE NOT ELIGIBLE

Temporary and Seasonal employees.

Part-time employees - those who are regularly scheduled to work less than 30 hours per week.

WHEN EMPLOYEES CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

The end of the month following the date your employment terminates.

The end of the month following the date you cease to be in a class of employees eligible for coverage.

The end of the month following the date you cease to be an eligible employee.

The end of the period for which you made any required contributions, if you fail to make any further required contributions.

The date the Plan is terminated.

The date you enter the armed forces of any country on a full-time active duty basis.

If you are absent from work due to an approved leave of absence, other than a Family and Medical Leave Act leave, or the Victims' Economic Security and Safety Act leave, coverage will continue as long as required contributions are made and the Plan Administrator has approved the leave of absence.

If you are absent from work due to a temporary layoff, coverage will terminate the last day of the month following the temporary layoff.

If you are absent from work due to a disability, coverage will continue as long as required contributions are made and the Plan Administrator has approved the disability leave.

This Plan intends to comply with the provisions of the Family and Medical Leave Act (FMLA) and the Victims' Economic Security and Safety Leave Act.

Refer to the section entitled COBRA for information regarding continued coverage after you cease to be eligible under the Plan.

The Employer or Plan has the right to rescind any coverage of the Retiree and/or Dependent for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the covered Retirees and/or covered Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Retiree's and/or Dependent's paid contributions.

FAMILY MEDICAL LEAVE ACT (FMLA)

If a Covered Employee ceases active service due to a Company approved Family Medical Leave of absence in accordance with the requirements of Public Law 103-3 (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had the Covered Employee continued active service.

If the Covered Employee does not return to active service after the approved Family Medical Leave or if the Covered Employee has given the employer notice of intent not to return to active service during the leave, or if the Covered Employee has exhausted the applicable twelve (12) or twenty-six (26) week FMLA leave entitlement period, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Employee elects to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. the Covered Employee or Covered Dependent was covered under this Plan on the day before the FMLA leave began or becomes covered during the FMLA leave; and
2. the Covered Employee does not return to active service after an approved FMLA leave; and

3. without COBRA, the Covered Employee or Covered Dependent would lose coverage under this Plan.

However, these conditions do not entitle a Covered Employee to COBRA if the Company eliminates, on or before the last day of the Covered Employee's FMLA leave, coverage under this Plan for the class of Employees (while continuing to employ that class of Employees) to which the Covered Employee would have belonged if the Covered Employee had not taken FMLA leave.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. the date a Covered Employee fails to return to active service after an approved family medical leave;
2. the date the Covered Employee informs the Company of intent not to return to active service; or
3. the date a Covered Employee exhausts the applicable twelve (12) or twenty-six (26) week FMLA leave entitlement period and does not return to active service.

The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period.

If a Covered Employee declines coverage during the FMLA leave period or if the Covered Employee elects to continue coverage during the family or medical leave and fails to pay the required contributions, the Covered Employee is still eligible under the Continuation of Coverage (COBRA) provision at the end of the FMLA leave. COBRA continuation will become effective on the last day of the FMLA leave.

The pre-existing conditions limitation will not apply if a Covered Employee does not experience a break in coverage of sixty- three (63) days or more (defined as a "significant break in coverage"). The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected, however, the covered employee is not required to pay any unpaid contributions for the time coverage had lapsed during the leave.

If a Covered Employee voluntarily terminates coverage under this Plan during the FMLA leave or if coverage under this Plan was terminated during an approved family medical leave due to non-payment of required contributions by the employee and the employee returns to active service immediately upon completion of that leave, coverage will be reinstated as if the employee remained in active service during the leave, including dependent coverage, without having to satisfy any waiting period, pre-existing conditions, limitations or evidence of good health provisions of this Plan, provided the employee makes any necessary contribution and enrolls for coverage within thirty-one (31) days of the return to active service.

VICTIMS' ECONOMIC SECURITY AND SAFETY LEAVE (VESSA)

If a Covered Employee ceases active service due to a Company approved Victims' Economic Security and Safety Leave of absence, coverage will be continued under the same terms and conditions which would have been provided had the Covered Employee continued active service.

If the Covered Employee does not return to active service after the approved VESSA or if the Covered Employee has given the employer notice of intent not to return to active service during the leave, or if the Covered Employee has exhausted the maximum VESSA leave entitlement period, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Employee elects to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. the Covered Employee or Covered Dependent was covered under this Plan on the day before the VESSA leave began or becomes covered during the VESSA leave; and
2. the Covered Employee does not return to active service after an approved VESSA leave; and
3. without COBRA, the Covered Employee or Covered Dependent would lose coverage under this Plan.

However, these conditions do not entitle a Covered Employee to COBRA if the Company eliminates, on or before the last day of the Covered Employee's VESSA leave, coverage under this Plan for the class of Employees (while continuing to employ that class of Employees) to which the Covered Employee would have belonged if the Covered Employee had not taken VESSA leave.

Continuation of Coverage (COBRA) will become effective on the last day of the VESSA leave as determined below:

1. the date a Covered Employee fails to return to active service after an approved leave;
2. the date the Covered Employee informs the Company of intent not to return to active service; or
3. the date a Covered Employee exhausts the maximum VESSA leave entitlement period and does not return to active service.

The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period.

If a Covered Employee declines coverage during the VESSA leave period or if the Covered Employee elects to continue coverage during the leave and fails to pay the required contributions, the Covered Employee is still eligible under the Continuation of Coverage (COBRA) provision at the end of the VESSA leave. COBRA continuation will become effective on the last day of the VESSA leave.

The pre-existing conditions limitation will not apply if a Covered Employee does not experience a break in coverage of sixty- three (63) days or more (defined as a "significant break in coverage"). The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected, however, the covered employee is not required to pay any unpaid contributions for the time coverage had lapsed during the leave.

If a Covered Employee voluntarily terminates coverage under this Plan during the VESSA leave or if coverage under this Plan was terminated during an approved VESSA leave due to non-payment of required contributions by the employee and the employee returns to active service immediately upon completion of that leave, coverage will be reinstated as if the employee remained in active service during the leave, including dependent coverage, without having to satisfy any waiting period, pre-

existing conditions, limitations or evidence of good health provisions of this Plan, provided the employee makes any necessary contribution and enrolls for coverage within thirty-one (31) days of the return to active service.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services (defined below). In addition to the rights that you have under COBRA, you (the Employee) are entitled under USERRA to continue the coverage that you (and your covered Dependents, if any) had under the Medical and/or Dental Plan.

You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

Definitions

“Uniformed Services” means the Armed Forces, The Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

“Service in the uniformed services” or “service” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.

Duration of USERRA Coverage

General Rule: Twenty-four (24) month maximum. When a Covered Employee takes a leave for service in the uniformed services, USERRA coverage for the Employee (and covered dependents for whom coverage is elected) begins the day after the Employee (and covered dependents) lose coverage under the Plan, and it can continue for up to twenty-four (24) months. However, USERRA coverage will end earlier if one of the following events takes place:

1. A premium payment is not made within the required time;
2. You fail to return to work within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
3. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Returning to Work: Your right to continue coverage under USERRA will end if you do not notify the Company of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed services was for less than thirty-one [31] days) or applying for reemployment (if your uniformed services was for more than thirty [30] days). The time for returning to work depends on the period of uniformed services, as follows:

Period of	Return-to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight- hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
Period of	Return-to Work Requirement
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness To perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight- hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to eighteen (18) months (it may continue for a longer period and is subject to early termination, as described in the COBRA section. In contrast, USERRA coverage can continue for up to twenty-four (24) months, as described above.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage (or your spouse or your dependent children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

Questions

If you have any questions regarding this information or your rights to coverage, you should contact your Human Resources Department.

Reinstatement of Coverage

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under this Plan. The eligibility waiting period will be waived and the pre-existing condition limitation will be credited as if you had been continuously covered under this Plan from your original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused by or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer).

GINA

“GINA” prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

ELIGIBLE DEPENDENTS

Your legal spouse---See definition of "Spouse".

Your Civil Union Partner---See definition of “Civil Union Partner”.

Your unmarried dependent children under age nineteen (19) ---See definition of "Child".

Your Dependent Children under age twenty-six (26) who are not eligible to participate in any other employer sponsored group health coverage (their own employer or a spouse's employer) --- See definition of "Child.

A child who is under age eighteen (18) when he is placed with you for adoption and for whom you have assumed and retained a legal obligation for total or partial support in anticipation of adoption of such child.

A child you must cover due to a Qualified Medical Child Support Order (QMCSO) subject to the conditions and limits of the law.

Your unmarried Disabled Children over age twenty-six (26) if such Children were Disabled prior to attaining age twenty-six (26). You must provide satisfactory proof of each Child's incapacity and Dependency within thirty-one (31) days after the Child's twenty-sixth (26th) birthday. Continuing proof of disability and Dependency will be required periodically.

Anyone who is eligible for coverage as an employee will not be eligible for coverage as both an employee and as a dependent. Dependent children may not be covered by more than one employee.

If both parents are covered employees and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan provided the employee continues to be an eligible employee. If both a husband and wife are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining spouse's coverage.

If both partners in a Civil Union are covered employees and the partner carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the partner who remains covered by the Plan provided the employee continues to be an eligible employee. If both partners are covered employees and one terminates coverage with the Plan, he or she may be covered as a dependent under the remaining partner's coverage.

Extended Dependent Age Coverage

An additional category for dependent coverage has been added to the Plan due to the enactment of Illinois Public Act 95- 0958.

Unmarried military veteran dependent Children over age twenty-six (26) but under the age of thirty (30) who are not enrolled as a full-time student are eligible, residency requirement with the Employee is not required but the dependent must be a resident of Illinois.

In addition military veteran dependent Children must have:

- Served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
- Received a release or discharge other than a dishonorable discharge; and
- Submitted proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty".

The Plan will allow enrollment for these eligible dependents during the Plan's annual enrollment period. For Plans that do not have an annual enrollment period, enrollment will be allowed during the thirty (30) day period immediately prior to the Plan's renewal date. To be added during this time, eligible

dependents may need to meet a requirement of ninety (90) days of continuous coverage without a break in coverage of more than sixty-three (63) days.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If a Qualified Medical Child Support Order is issued for a Plan Participant's child, that child will be eligible for coverage as required by the order and the Plan Participant will not be considered a Late Entrant for Dependent coverage.

A description of the QMCSO procedures is available from the Plan Administrator upon request, free of charge.

SPECIAL ENROLLMENT PERIODS

In certain circumstances, you or your dependent may be eligible to enroll in the Plan outside the initial enrollment period or an annual enrollment period. In other words, you may enter the Plan during a "Special Enrollment Period." This section explains how an individual may be eligible for Special Enrollment rights.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period and, therefore, is not counted in the Pre-Existing Condition Limitation time.

1. **Individual losing other coverage.** An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
 - a. The Employee (or Dependent) was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - c. The coverage of the Employee (or Dependent) was terminated as a result of loss of eligibility (including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), and no COBRA was elected, or the coverage was provided through COBRA and the COBRA coverage was exhausted, or employer contributions toward the coverage were terminated.
 - d. The Employee requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Employee (or Dependent) lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

2. **Dependent beneficiaries.** If:

- a. The Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- b. A person becomes a Dependent of the Employee through marriage, Civil Union, birth, adoption or placement for adoption

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, Civil Union, birth, adoption or placement for adoption.

The coverage of the Dependents enrolled in the Special Enrollment Period will become effective:

- In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
 - In the case of a Civil Union, as of the date of the Civil Union; or
 - In the case of a Dependent's birth, as of the date of the birth; or
 - In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
3. **Children's Health Insurance Program Reauthorization Act of 2009.** An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enroll if:

- a. The Employee or Dependent was covered under Medicaid or the Children's Health Insurance Program at the time coverage under this Plan was previously offered to the individual; and

The Employee or Dependent loses eligibility for Medicaid or the Children's Health Insurance Program; and

The Employee or Dependent requests enrollment in this Plan not later than sixty (60) days after the date Medicaid or the Children's Health Insurance Program coverage ends; or

- b. The Employee or Dependent has declined enrollment for himself or Dependent and later becomes eligible for a premium assistance subsidy for group health coverage through Medicaid or the Children's Health Insurance Program; and

The Employee or Dependent requests enrollment in this Plan not later than sixty (60) days after the date of eligibility determination for a premium assistance subsidy for group health coverage through Medicaid or the Children's Health Insurance Program.

Coverage will become effective not later than the first day of the first month beginning after the date the completed request for enrollment is received.

DEPENDENTS EFFECTIVE DATE OF COVERAGE

You must enroll your Dependents for coverage under this Plan by completing an enrollment form and authorizing any required contributions.

Dependent coverage begins on the date on which you become eligible for Plan benefits.

If you apply for Dependent coverage on or before your eligibility date, or within thirty-one (31) days after your original eligibility date, coverage for your Dependents will begin on your original eligibility date.

If you acquire a Dependent after your original effective date of coverage, you must make written application for coverage for that Dependent within thirty-one (31) days of the date of the marriage, Civil Union, birth or adoption. If you apply for coverage for a Dependent within thirty-one (31) days following the date you acquire such Dependent, coverage for that Dependent will begin on the date of the marriage, Civil Union, birth or adoption.

If you do not apply for coverage within thirty-one (31) days after the date you become eligible, or thirty-one (31) days after the date you acquire your first eligible dependent, or during a Special Enrollment Period, or if you previously elected to end Dependent coverage in the Plan, you may apply for coverage during the annual enrollment period in November and the effective date of coverage will be December 1st, or at any time; however, the dependent will be subject to the Pre-Existing Conditions Limitations for Late Enrollees. The effective date of coverage will be six (6) months following the date you complete an enrollment card and make any required contributions.

A newborn child will automatically be covered at birth for thirty-one (31) days. For coverage to continue beyond thirty-one (31) days, you must notify the Company of the birth and authorize any required contributions. If notification and required contributions are not made, coverage for the newborn child will terminate at the end of the thirty-one (31) day period. Submission of a medical claim is not considered notification for continuation of coverage.

WHEN DEPENDENTS CEASE TO BE ELIGIBLE

All Plan coverage will terminate on the earliest of the following dates:

In the case of all your Dependents, the date your coverage terminates or the Dependent ceases to be a Dependent as defined in this Plan.

In the case of your Spouse, when you are legally separated or divorced.

In the case of your Civil Union Partner, when your Civil Union is legally dissolved.

In the case of a Dependent Child, attaining age twenty-six (26) or becoming eligible to participate in any other employer sponsored group health coverage (their own employer or a spouse's employer), whichever occurs first.

In the case of a Dependent Child who is an unmarried military veteran, residing in Illinois, attaining age thirty (30).

In the case of a Disabled Child, when the Dependent is no longer disabled or dependent upon you for support. The date the Dependent Coverage is discontinued under the Plan.

The date the Dependent becomes covered as an employee.

The date the Dependent enters the armed forces of any country on a full-time active duty basis.

The end of the period for which you made any required contributions, if you fail to make any further required contributions.

Refer to the section entitled COBRA for information regarding continued coverage after a Dependent ceases to be eligible under the Plan. **NOTE:** A Civil Union Partner is not eligible for COBRA.

The Employer or Plan has the right to rescind any coverage of the Retiree and/or Dependent for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the covered Retirees and/or covered Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Retiree's and/or Dependent's paid contributions.

PRE-EXISTING CONDITION LIMITATION PROVISION & CREDITABLE COVERAGE

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months of the person's enrollment date. For these purposes, Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by, or received from, a Physician.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Benefits are not payable for expenses related to a Pre-Existing Condition unless the expense is incurred more than twelve (12) consecutive months from the Enrollment Date.

The period of the Pre-Existing Condition Limitation must be reduced by the number of days of "Certified Creditable Coverage" an individual has as of the Enrollment Date. The Plan is required to credit periods of previous coverage toward a Pre-Existing Condition period. Therefore, the length of a Pre-Existing Condition Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan. To receive credit for periods of previous coverage, an eligible individual must not experience a break in coverage of sixty-three (63) days or more (defined as a "significant break in coverage"). Waiting periods are not considered breaks in coverage. Days in a waiting period are not Creditable Coverage.

An eligible person may request a certificate of Creditable Coverage from his prior plan. The Certificate of Creditable Coverage will enable the Plan to determine whether the Pre-Existing Condition Limitation will be reduced or eliminated. The Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

A person may request a certificate of Creditable Coverage from the Plan by requesting such certificate in writing from the Claims Administrator. No certificate shall be issued by the Plan if requested more than twenty-four (24) months from the date coverage under the Plan terminated.

The Pre-Existing Condition Limitation does not apply to:

- ♦ Pregnancy;
- ♦ To a newborn child within thirty-one (31) days of birth who is covered under Creditable Coverage, or
- ♦ To a child who is adopted or placed for adoption before attaining age eighteen (18) and who, as of the last day of the thirty-one (31) day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage;
- ♦ The Pre-Existing Condition Limitation does not apply to a Covered Person less than nineteen (19) years of age.
- ♦ Employees and covered Dependents of Employees who are returning from a leave which qualifies under the Family and Medical Leave Act (FMLA) and chose not to retain coverage under the Plan during the leave.

The prohibition on exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any Creditable Coverage.

PREFERRED PROVIDER ORGANIZATION (PPO)

Certain Hospitals and Physicians may participate in a PPO Network. PPO providers have entered into an agreement to provide services at a discounted fee arrangement. The PPO offers access to quality health care services by conveniently located providers at substantial savings to the Covered Persons. Each Covered Person is responsible for verifying a provider's network membership status prior to each and any service to ensure the claim is covered at the higher benefit level. If your current providers are not participating in the PPO Network, ask your providers to contact the Network for an application for participation or, you can nominate the provider on the Network's website or call their provider referral department. The PPO Network can only provide the names, addresses, and phone numbers of participating providers; they cannot pre-certify a procedure or verify eligibility or benefits. A list of the Hospitals and Physicians participating in the PPO is also available through the internet or by calling the provider network that is listed on the ID card. A list may also be obtained free of charge from the Plan Administrator.

A Covered Person has freedom of choice in selecting a health care provider; however, there are benefit differences depending on whether services are rendered by a Network provider or by a Non-Network provider. These differences are shown on the Schedule of Benefits.

If a Covered Person is located in an area where Network providers are not available, the Non -Network benefits will apply.

If a Covered Person requires treatment for an accident or medical emergency, as defined, benefits for the initial treatment by a Non-Network provider will be paid as shown on the Schedule of Benefits.

If charges are incurred for services performed by a Non-Network provider which the patient did not have the option to choose, which relate to:

- ♦ **A Network Confinement;**
- ♦ **A Network Out-Patient Procedure; or**
- ♦ **A Network Physician/Office Visit,**

(i.e., *Assistant Surgeon, Anesthesia, Independent Lab, Pathology & X-Ray, etc.*) benefits will be paid as shown on the Schedule of Benefits.

Should you choose a provider that is participating in the PPO network, that provider will discount fees charged for the services rendered. Such discounts will be identified on your Explanation of Benefits (EOB). The discounts offered by the participating providers will be credited to your billing record. Should you ever be billed by a PPO provider for the discounts, notify the Claims Administrator who will then contact the provider for the appropriate adjustment.

IMPORTANT

The requirements of the Utilization Review program described herein must be followed in order to receive full benefits under the Plan, whether a Network or Non-Network provider is used. In addition, when using a Network provider, benefits must be assigned to that provider.

UTILIZATION REVIEW PROGRAM

This Plan has implemented a program of Utilization Review so that you understand the medical necessity of a proposed Hospital confinement, surgery, or other care recommended by your Physician. The Utilization Review Service is staffed by medical professionals who consult with you and your Physician to determine the type of care required, the appropriate setting for such care, and quality, yet cost effective care for your condition.

Prior to receiving treatment for any of the services listed below, please contact the Utilization Review Manager as shown on your ID card. You must call at least 72 hours prior to an elective procedure or admission and no later than 72 hours after an emergency procedure or admission. Failure to obtain pre-certification may result in a reduction of benefits as stated above.

ALL BENEFITS PROVIDED BY THIS PLAN FOR THE CARE LISTED BELOW ARE SUBJECT TO THE REQUIREMENTS OF THIS SECTION:

- All Hospitalizations
- Transplant Services (including transplant evaluation)
- Inpatient Rehabilitation Facility Stays
- All Substance Abuse Treatment
- All Mental Disorder Treatment
- Skilled Nursing Facility Stays
- Home Health Care
- Hospice Care
- Physical Therapy (PT)
- Dialysis
- Speech Therapy (ST)
- Occupational Therapy (OT)
- Cardiac Rehabilitation Therapy
- Outpatient Surgery
- Chemotherapy & Radiation Therapy
- Durable Medical Equipment Costing Over \$500
- Pre-natal and Maternity Care
- MRI & CT Scans

Pre-Certification is not a guarantee of benefits, eligibility, payment, nor is it a medical treatment decision or advice. The program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other Health Care Provider.

PRE-ADMISSION REVIEW

For Non-Emergency Hospital Admissions or Care:

A pre-admission authorization is required at least seventy-two (72) hours prior to admission to a hospital as a bed patient. You, a member of your family, your physician or the hospital must call the Utilization Review Service whenever a hospital admission is recommended.

The Utilization Review Service will evaluate your planned treatment based upon the diagnosis provided by your physician and established standards for medical care. After consultation with your physician the Utilization Review Service will provide authorization to you, the hospital, and the Claims Administrator.

The Utilization Review Service's authorization does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

For Emergency Hospital Admissions or Care:

"Emergency Hospital Admission" means an admission for hospital confinement which, if delayed, would result in disability or death.

In case of an emergency hospital admission or care, you, your physician, the provider or a member of your immediate family must inform the Utilization Review Service of the admission, by telephone, within seventy-two (72) hours after such admission or care.

The Utilization Review Service must be informed of:

- ♦ Provide the name and date of birth of the patient
- ♦ Provide the name, Plan, id number, address and phone number of the employee
- ♦ Provide the name and phone number of the facility where the services will be performed
- ♦ Provide the name and phone number of the doctor ordering the services
- ♦ Give a brief explanation to the RN of what service is being done and why
- ♦ Write down the reference number that the RN gives to you and present it when you go for the services

CONTINUED STAY REVIEW

Before your scheduled discharge the Utilization Review Service will call the hospital and your physician to confirm your discharge. If additional days of confinement are required because of complications or other medical reasons, the Utilization Review Service will again evaluate the treatment and diagnosis in consultation with your physician. This process will continue until you are discharged from the hospital.

If hospital charges are incurred by a Covered Person for a period of hospital confinement which has NOT been authorized under the Continued Stay Review provisions, the eligible hospital charges for such confinement will be limited to the charges incurred during the period of hospital confinement initially authorized.

IF UTILIZATION REVIEW IS NOT USED

If hospital charges are incurred by a Covered Person for a period of hospital confinement and such confinement has NOT been authorized by the Utilization Review Service as set out under the Pre-Admission Review provisions, the penalty, as shown on the Schedule of Benefits, will apply.

THE NON-COMPLIANCE PENALTIES WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLE(S) OR TO THE OUT-OF-POCKET MAXIMUMS.

RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose hospital stay, or a portion of his stay, was not authorized under the Pre-Admission and/or Continued Stay Review provisions of the Plan.

Requests for such review must be made by the attending physician or hospital and must define the medical basis for the review.

Benefits will be limited to only those expenses incurred during the period of hospitalization which **would have been** authorized. Benefits are not payable for expenses related to any period of hospital confinement which is deemed not medically necessary.

VOLUNTARY SECOND SURGICAL OPINION BENEFIT

If your physician recommends non-emergency surgery, meaning surgery that can be postponed without causing undue risk, the Plan will pay 100% after the Co-Pay for any necessary physician, x-ray or laboratory expense incurred for a second surgical opinion (and a third opinion, if the second opinion does not agree with the first opinion), with no deductible required, if:

- ♦ The physician providing the second or third opinion is not associated with the physician who first recommended surgery.
- ♦ The physician providing the second or third opinion does not perform the surgery.
- ♦ The second or third opinion is obtained before the recommended surgery.
- ♦ The physician providing the second or third opinion is a Board Certified specialist in the appropriate specialty.
- ♦ The physician places the second or third opinion in writing.

An opinion confirming the advisability of surgery may provide greater peace of mind, and a non-confirming opinion may provide an alternative non-surgical method of treatment for the medical condition. If the patient does not use the Benefit, he will be passing up the chance to get additional medical advice.

The Second Surgical Opinion Benefit DOES NOT apply to expenses incurred for or in connection with:

- ♦ Surgical procedures which are not covered under the Plan;
- ♦ Minor surgical procedures that are routinely performed in a physician's office, such as incision and drainage of an abscess or excision of benign lesions;

An opinion obtained more than three (3) months after a surgeon first recommended the elective surgical procedure.

ALTERNATIVE TREATMENT OPTIONS

Alternative Treatment Options Coordinated by the Case Manager are covered. Once agreement has been reached, the Case Manager will advise the Claims Administrator to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. These exceptions to plan design are not establishing precedent. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriated or recommended for any other patient, even one with the same diagnosis

CASE MANAGEMENT SERVICES

Individual Case Management

Case Management is conducted to ensure that your course of treatment meets evidence based clinical guidelines and is eligible for benefits under the Plan. These activities are conducted with a focus on patient advocacy in compliance with applicable regulatory requirements.

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MEDICAL EXPENSE BENEFIT

To receive benefits under the Medical Expense Benefit, you must satisfy the Deductible amount shown on the Schedule of Benefits. Once you have satisfied the Deductible, benefits are payable as shown on the Schedule of Benefits.

THE DEDUCTIBLE AMOUNT

The Individual Deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Medical Expenses that you or your dependents must satisfy in a Calendar Year before you or your dependents are eligible to receive the Medical Expense Benefit.

Co-payments do not apply toward satisfaction of the Deductible.

FAMILY DEDUCTIBLE

When Covered Family Members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Medical Expense Deductibles to the remaining Covered Medical Expenses for all Covered Family Members for that Calendar Year.

COMMON ACCIDENT DEDUCTIBLE

If two (2) or more Covered Family Members are injured in the same accident only one (1) Deductible will apply to all Covered Medical Expenses incurred as a result of that accident during the Calendar Year of the accident.

The payment of benefits and the satisfaction of the Medical Expense Deductible as described apply only to those injuries sustained in the accident. Covered charges related to any other injury or illness will be payable on a separate basis as though this provision had not been included.

CO-INSURANCE FACTOR

After the Deductible is satisfied, the Plan will pay the applicable percentages of eligible Medical Expenses as shown on the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

If, in a Calendar Year, a Covered Person accumulates an Out-of-Pocket amount which equals the amount shown on the Schedule of Benefits, the Plan will pay 100% of any further Covered Medical Expenses incurred during the remainder of that Calendar Year.

Tier I/ Tier II and Tier III expenses will be applied equally toward the satisfaction of both Tier I/Tier II and Tier III Out- of-Pocket Maximums.

Co-payments continue to be the responsibility of the Covered Person.

FAMILY OUT-OF-POCKET MAXIMUM

When Covered Family Members have satisfied the Family Out-of-Pocket Maximum amount shown on the Schedule of Benefits in a Calendar Year, the Plan will not apply the Co-Insurance Factor to and will pay 100%, from that date forward, of any further Covered Medical Expenses for all Covered Family Members for the remainder of that Calendar Year.

NOTE: Expenses Related To Satisfaction Of The Individual Or Family Deductibles, Per Visit Co-Payments, Prescription Drug Co-Payments, Psychiatric And Substance Abuse Treatment, Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees, And Non-Compliance Penalties Do Not Accumulate Toward The Out- Of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The Tier I/Tier II and Tier III Level Of Benefits.

COVERED MEDICAL EXPENSES

Reasonable and Customary charges incurred by, or on behalf of, a Covered Person for the following medically necessary items, if performed or prescribed by a physician for an injury or illness, subject to the Exclusions and Limitations of the Plan, are covered by the Medical Expense Benefit:

1. Hospital Room and Board including bed and board, general nursing care, meals and dietary services provided by the hospital. All semi-private or ward accommodations are covered.
 - a. For private rooms, an allowance will be paid equal to the hospital's semi-private room charge.
 - b. If the hospital only has private room facilities, private room charges will be considered as semi-private charges.
 - c. If a private room is medically necessary for isolation purposes, the private room charge will be considered as semi-private.
 - d. If Intensive Care, Coronary and Intermediate Care accommodations are medically necessary, the hospitals actual charges are covered.
2. Miscellaneous Hospital services and supplies including equipment and medications provided to registered inpatients.
3. Hospital charges for medically necessary outpatient services.
4. Services and supplies furnished by an ambulatory surgical center.
5. Extended Care Facility services (refer to the specific section for coverage details).
6. Home Health Care services (refer to the specific section for coverage details).
7. Hospice Care services (refer to the specific section for coverage details).
8. Physician's services for surgery or other necessary medical care whether rendered in the office, hospital, home, extended care facility or hospice.
9. Chiropractic care, by any name called, including all professional services for the detection and correction by manual or mechanical means (with or without the application of treatment modalities such as, but not limited to diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions. Such care may not be considered a covered expense if it is determined to be maintenance palliative. ***Benefits are limited to the amount shown on the Schedule of Benefits.***
10. Licensed Psychologist's and licensed clinical Social Workers' professional medical services for the treatment of psychiatric disorders and substance abuse that would be covered if provided by a doctor of medicine (M.D.) and only when the psychologist or social worker is acting within the scope of his license.

11. Chemotherapy or radiation therapy by x-ray, radium, radon or radioactive isotopes, or other such treatment or care recommended or prescribed by a Physician.
12. Renal dialysis treatment, including equipment and supplies when such services are provided in a hospital, dialysis facility or in the home under the supervision of a hospital or dialysis facility.
13. Charges for physical and/or occupational therapy rendered by a licensed or registered physical or occupational therapist or chiropractor (D.C.), for the purposes of training to aid the restoration of normal physical functions lost due to an illness or injury. ***Benefits for physical therapy are limited to the amount shown on the Schedule of Benefits and will include charges rendered by a chiropractor (D.C.).***
14. Restorative or rehabilitative speech therapy by a qualified speech therapist when such therapy is administered:
 - a. To a Covered Person whose previously-unimpaired speech is affected by an illness or injury; or
 - b. To a Dependent Child as part of such Child's treatment for cerebral palsy or following surgery to correct a congenital anomaly of such Child.
15. Charges for reconstructive or cosmetic surgery provided the following conditions are met:
 - a. The surgery must be required to correct a condition that results from an illness or injury; or
 - b. The surgery is required to correct the congenital anomaly of a Dependent Child.

Cosmetic surgery related to acne is not a covered expense.

16. Charges for the following expenses related to breast reconstruction in connection with a mastectomy in a manner determined in consultation with the attending physician and the patient:
 - a. Reconstruction of the breast on which the mastectomy has been performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.
17. Charges made by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing services when the attending physician certifies that such nursing care is medically necessary.
18. Anesthesia and its administration when rendered by a physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or an ambulatory surgical facility.
19. Medically necessary abortions.
20. Covered services related to the diagnosis and/or treatment of infertility including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and

injectable medication and infertility drugs. Infertility shall mean the inability to conceive a child after one (1) year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- a. The Covered Person has been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment;
- b. The Covered Person has not undergone four (4) completed oocyte retrievals, except, if a live birth followed a completed oocyte retrieval, two (2) or more oocyte retrievals shall be covered. In no event will more than six (6) oocyte retrievals be covered by this Plan.

Benefits will not be provided for the following:

- a. Services rendered to a surrogate mother for purposes of child birth;
- b. Reversal of voluntary sterilization;
- c. Costs for cryo preservation and storage of sperm, eggs and embryos;
- d. Selected termination of an embryo unless the mother's life would be in danger were all embryos carried to full term;
- e. Non-medical costs of an egg or sperm donor;
- f. Travel costs within 100 miles of the insured's home or travel costs not medically necessary; or
- g. Infertility treatments or services deemed experimental in nature.

In addition, if in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures for the treatment of infertility are received, the procedures must be performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or the American Fertility Society minimal standards for programs of in-vitro fertilization.

- 21. Charges for obstetrical care are paid on the same basis as any other illness, including pre-natal care, pregnancy, and miscarriages. Benefits are provided for the pregnancy of a Dependent Child; however, benefits are not payable for the newborn unless and until the Employee (the grandparent) becomes the legal guardian for that child.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In

addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

22. Charges incurred in connection with a Birthing Center (in lieu of hospital confinement) and medically necessary supplies furnished to the mother and necessary supplies furnished to the covered newborn child.
23. Routine newborn care while hospital confined, including hospital nursery care and other hospital services and supplies and physicians charges for pediatric care and circumcision.
24. Voluntary sterilizations, but not the reversal of such procedures.
25. Well-baby and well-child care for dependent children as defined in the Schedule of Benefits.
26. Medically Necessary pain medication and pain therapy related to the treatment of breast cancer.

Mammograms according to the following schedule, including digital mammography:

- A baseline mammogram for women age 35-39 years of age
- An annual mammogram for women age 40 and older
- A mammogram when Medically Necessary for women under age 40 having a family history of breast cancer, prior personal history of breast cancer or other risk factors.

A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue when Medically Necessary as determined by a physician.

Mammograms and the ultrasound are covered at 100%, not subject to a co-pay or deductible and not subject to any annual or lifetime maximum benefit.

Clinical breast examinations.

27. Pap smear for routine cancer screening and the related office visit.
28. Routine Physical Examinations. The Plan will provide benefits up to the maximum benefit shown on the Schedule of Benefits, for charges made or ordered by a physician for routine services for covered adults and children from age 7 and older.

This benefit does not include any expenses incurred in connection with a diagnosed illness or physicals required by a third party.

Expenses in excess of the maximum benefit stated in the Schedule of Benefits will then apply to the deductible and co-insurance.

29. Blood and blood plasma to the extent not donated or replaced.
30. X-ray and laboratory examinations, including allergy testing, for diagnostic or treatment purposes.

31. Professional ambulance service to and from a hospital or extended care facility where medical care and treatment necessary for the illness or injury can be provided, or
 - a. Between hospitals and extended care facilities when a transfer is necessary to provide adequate care, or
 - b. Regularly scheduled airline or railroad or air ambulance from the city in which the Covered Person became ill or was injured to and from the nearest hospital that provides treatment for such illness or injury. Only charges incurred for the first trip to and from a hospital shall be included.
32. Durable Medical Equipment limited to the lesser of the purchase price or the total anticipated rental charges. If the purchase or anticipated rental exceeds \$500, pre-approval by the Claims Administrator is required.
33. Charges for artificial limbs, eyes and other prosthetic devices to replace physical organs and body parts, including replacements which are medically necessary or required by pathological change or normal growth. Covered charges do not include expenses for the repair or replacement of damaged, lost or stolen devices.
34. Medical and surgical supplies including bandages and dressings.
35. Casts, splints, crutches, cervical collars, head halters, traction apparatus and orthopedic braces.
36. Oxygen and rental of equipment for its administration.
37. The first pair of glasses or contact lenses, but not both, prescribed to treat glaucoma or keratoconus or resulting from cataract surgery.
38. Diabetic Self-Management Training. ***Benefits are limited to the amount shown on the Schedule of Benefits.***
39. Human Organ Transplants:

Coverage includes benefits for medically necessary expenses related to human organ, bone marrow and tissue transplants. Expenses incurred by a live organ donor, who is without insurance coverage and is not covered under this Plan, will be covered. Expenses incurred for organs obtained through an organ bank or from a cadaver and expenses for storage and transportation that are reasonable and customary, are covered under this Plan. If both the recipient and the donor are covered under this Plan, the expenses will be treated separately.

Benefits are payable for covered expenses for services or supplies incurred by you and your travel companion while traveling to and from a transplant program provider up to the travel allowance maximum benefit as shown on the Schedule of Benefits. The transplant program provider must be located 50 miles or more from your home for benefits to be payable.

Benefits that are payable under this provision are subject to the following limitations:

- a. Transportation as a passenger in or on a public vehicle provided by a common carrier for passenger service to a transplant program provider.

- b. Transportation to the transplant program provider using a motor vehicle, will be payable in accordance with the current IRS allowance per mile for medical travel.
 - c. Hotel accommodations at moderately priced hotels for you should you be released to an outpatient facility for medically necessary post-surgical care from the transplant program provider.
 - d. Hotel accommodations at moderately priced hotels for your travel companion to remain in the immediate area of the transplant program provider for all or a portion of the duration of your treatment plan.
 - e. Daily meals and other reasonable and necessary services or supplies incurred by you and your travel companion.
40. Drugs and medications requiring a physician's written prescription (including insulin and insulin syringes), excluding over-the-counter medications.

Drugs and medications purchased through the Prescription Drug Plan will be covered as shown on the Schedule of Benefits.

Maintenance medications obtained through a Mail Order Prescription Drug Plan are payable as shown on the Schedule of Benefits.

41. Expenses for prescription birth control, including oral contraceptives, the patch, depo provera, injectables, etc.
42. Expenses for the following dental related services and supplies:
- a. Treatment for the repair or alleviation of damage to sound natural teeth due to an accidental injury, other than from eating or chewing, or treatment of an injury to the jaw due to an injury. Treatment must be rendered within twelve (12) months of the injury.
 - b. Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia.
 - c. Biopsies of the oral cavity and related anesthesia.
 - d. Removal of partial and full bone impacted teeth and related anesthesia.
 - e. Expenses billed by a hospital for inpatient and outpatient dental services will be covered if the Covered Person has a serious medical condition that requires hospitalization.

43. Inpatient, Partial, and Outpatient Psychiatric and Substance Abuse:

Expenses are subject to the Deductible, Co-Insurance percentages and Benefit Maximums shown on the Schedule of Benefits.

44. Wigs when needed due to chemotherapy/radiation therapy. ***Benefits are limited to the amount shown on the Schedule of Benefits.***

45. ***Tier One and Tier Two Providers Only*** - FDA approved medications used for conditions other than those for which they received FDA approval, when considered the standard of care and ***not*** part of a clinical study or in conjunction with any experimental treatment. For the purposes of this Plan, Standard of Care is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, National Comprehensive Cancer Network (NCCN), or the National Institute of Health, and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness.
46. Charges for the diagnosis and treatment of Autism Spectrum Disorder for children under age twenty-one (21). Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Diagnosis means one or more tests, evaluations or assessments to diagnose whether an individual has Autism Spectrum Disorder that is prescribed, performed or ordered by a physician licensed to practice medicine in all its branches or a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorder.

Treatment shall include the following care when prescribed, provided or ordered by a physician or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder when the care is determined to be Medically Necessary.

Psychiatric care;

Psychological care;

Habilitative or rehabilitative care including professional, counseling and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain and restore the functioning of an individual. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior; and

Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

Self-care and feeding;

Pragmatic, receptive and expressive language;

Cognitive functioning;

Applied behavioral analysis, intervention and modification;

Motor planning; and

Sensory processing.

Upon request a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the Plan may request a treatment plan

consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

When making a determination of medical necessity for a treatment modality for Autism Spectrum Disorders, the Plan must make the determination in a manner that is consistent with the manner used to make that determination for other diseases or illnesses. Any challenge to medical necessity must be reviewed by a physician with expertise in the most current and effective treatment modalities for Autism Spectrum Disorders.

Coverage for Medically Necessary early intervention services must be provided by certified early intervention specialists.

47. Charges for a shingles vaccine age sixty (60) and older.
48. Charges for a human papillomavirus vaccine (HPV).
49. Medically necessary preventative physical therapy for Covered Persons diagnosed with multiple sclerosis. Preventative physical therapy must be prescribed by a Physician and must include reasonably defined goals, including but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.
50. Habilitative services as required by Illinois Law for children under nineteen (19) years of age which includes occupational, physical and speech therapies and other services prescribed by the child's Physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

Charges will be subject to the following:

- A licensed Physician has diagnosed the child's congenital, genetic, or early acquired disorder.
- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist, upon the referral of a physician.
- The initial or continued treatment must be medically necessary and not experimental or investigational.
- Services that are solely educational in nature or otherwise paid under State or Federal law for purely educational services will not be considered eligible.
- When continued treatment is or will be required to permit the patient to achieve demonstrable progress the provider may be asked to submit a treatment plan which includes diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

51. Surveillance tests for ovarian cancer for women at risk for ovarian cancer. Surveillance tests mean annual screening using (i) CA-125 serum tumor marker testing, (ii) transvaginal ultrasound, and (iii) pelvic examination.
52. Tobacco use cessation programs, limited to one (1) per calendar year, provided the Covered Employee elects this optional benefit and pays the required premium.

EXTENDED CARE FACILITY

The Plan will provide benefits to the maximum shown on the Schedule of Benefits, per Convalescent Period, for charges made by an Extended Care Facility for convalescing from an illness or injury. Covered charges include:

- ♦ Room and board including charges for services such as general nursing care made in connection with room occupancy. The charge for daily room and board is limited to 50% of the semi-private room rate in the last hospital in which the Covered Person was confined,
- ♦ Use of special treatment rooms, x-ray and laboratory examination, physical, occupational, or speech therapy and other medical services customarily provided by an Extended Care Facility except private duty or special nursing services or physician's services,
- ♦ Drugs, biological solutions, dressings, casts and other medically necessary supplies.

Convalescent Period - A "convalescent period" begins on the first day an individual is confined in an Extended Care Facility if:

- ♦ The attending physician certified that twenty-four (24) hour nursing care is necessary for the recuperation from an injury or illness which required the hospital confinement, and
- ♦ He is confined in the Extended Care Facility to receive skilled nursing and physical restorative services for convalescence from the illness or injury that caused that hospital confinement.

Even though there may be several non-consecutive confinements in an Extended Care Facility, the "Convalescent Period" will continue until there has been a period of ninety (90) consecutive days during which the individual has been free of confinement in a hospital, Extended Care Facility or other institution providing nursing care.

HOME HEALTH CARE

The Plan will provide benefits to the maximum shown on the Schedule of Benefits, for charges made by a licensed Home Health Care Agency for the following services and supplies furnished to a Covered Person in his home, or the place of residence used as such person's home for the duration of his illness or injury, for care in accordance with a Home Health Care Plan.

The care must be administered in lieu of a Hospital or Extended Care Facility confinement. Expenses for, but not limited to, the following are covered under this benefit:

- ◆ Part-time or intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).
- ◆ Part-time or intermittent home health aide services.
- ◆ Physical, occupational, respiratory and speech therapy.
- ◆ Medical supplies, drugs and medicines prescribed by a physician, and x-ray and laboratory services.
- ◆ Medical social services.
- ◆ Nutritional counseling.
- ◆ Renal Dialysis

The following Home Health Care Expenses are not covered under the Plan:

- ◆ Meals, personal comfort items and housekeeping services.
- ◆ Services or supplies not prescribed in the Home Health Care Plan.
- ◆ Services of a person who ordinarily resides in your home, or who is a member of your or your spouse's family.
- ◆ Transportation services.
- ◆ Treatment of psychiatric conditions of any type, including substance abuse.

HOSPICE CARE

The Plan will provide benefits to the maximum shown on the Schedule of Benefits for care received through a home or inpatient Hospice Care program to which a terminally ill patient was referred by his attending physician. Expenses for, but not limited to, the following are covered under this benefit:

- ♦ Inpatient Hospice, limited to the semi-private room rate.
- ♦ Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.).
- ♦ Physical, occupational, respiratory and speech therapy.
- ♦ Medical social services.
- ♦ Part-time or intermittent home health aide services.
- ♦ Medical supplies, drugs, and medicines prescribed by a physician, and x-ray and laboratory services.
- ♦ Physician's services.
- ♦ Dietary counseling.
- ♦ Bereavement counseling for immediate family members.

The following Hospice Care expenses are not covered under the Plan:

- ♦ Transportation services.
- ♦ Financial or legal counseling for estate planning or drafting a will.

PRESCRIPTION DRUG PROGRAM

The Plan provides benefits for eligible prescription drugs and medicines through a Prescription Drug Program. Present your

I.D. card to the participating pharmacist at the time you fill or refill a prescription for yourself or your covered dependent.

You will pay a co-payment for each prescription, or the actual cost if less than the co-payment. The co-payment amounts are shown on the Schedule of Benefits.

Maintenance prescription drugs and medications requiring a physician's written prescription are available through the Mail Order Prescription Drug Program. For further details refer to the Mail Order brochure available from the Human Resources Department.

Prescription drugs and medicine which are purchased through an out of network pharmacy will be payable at 75% after the appropriate co-payment. Documentation must be submitted along with the prescription drug receipt indicating the pharmacy is out of network.

MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS

In addition to Exclusions and Limitations stated elsewhere in this Plan, the Medical Provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

1. Hospitalization, services or supplies which are not medically necessary. Medically necessary hospitalization, services or supplies are those which are required for treatment of the illness or injury for which they are performed, which meet generally accepted standards of medical practice, and which are provided in the most cost-effective manner. Medically necessary hospital inpatient services are those which require inpatient care in an acute care hospital and cannot safely and effectively be provided in a physician's office, hospital outpatient department or other facility.
2. Charges for experimental drugs that:
 - a. Are not commercially available for purchase;
 - b. Are not approved by the Food and Drug Administration (FDA) for general use;
 - c. Are not being used for the condition or illness for which they received FDA approval, except as shown as a covered expense.
 - d. Are not recognized by state or national medical communities, Medicare, Medicaid or other governmental financed programs.
3. Charges for any care, treatment, services or supplies that are:
 - a. Not approved or accepted as essential to the treatment of any illness or injury by any of the following: the American Medical Association, the U.S. Surgeon General, the U.S. Department of Public Health, or the National Institute of Health; or
 - b. Not recognized by the medical community as potentially safe and efficacious for the care and treatment of the injury or illness.
4. Custodial care - That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed and supervision over medication which can normally be self-administered.
5. Milieu therapy or any confinement in an institution primarily to change or control one's environment.
6. Services or supplies received during an inpatient stay when the stay is primarily for behavioral problems or social maladjustment or other anti-social actions which are not specifically the result of mental illness.
7. Reconstructive or cosmetic surgery, except for reconstructive surgery following a mastectomy or the correction of congenital deformities or conditions resulting from an illness or injury. Cosmetic surgery related to acne is not a covered expense.

8. Personal hygiene, comfort or convenience items that do not qualify as Durable Medical Equipment and are generally useful to the Covered Person's household, including but not limited to:
 - a. All types of beds, other than hospital type beds that qualify as a Covered Expense;
 - b. Air conditioners, humidifiers, air cleaners, filtration units and related apparatus;
 - c. Whirlpools, saunas, swimming pools and related apparatus;
 - d. Medical equipment generally used only by Physicians in their work;
 - e. Vans and van lifts, stair lifts and similar other ambulatory apparatus;
 - f. Exercise bicycles and other types of physical fitness equipment.
9. Special braces, splints, equipment, appliances, battery or anatomically controlled implants unless medically necessary.
10. Expenses for physical therapy or occupational therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function, except as shown as a covered expense.
11. Speech therapy unless it is required because of a physical impairment caused by an illness, injury, or congenital deformity, except as shown as a covered expense.
12. Recreational or educational therapy or forms of non-medical self-care or self-help training and any diagnostic testing.
13. Elective abortions, except where necessary to preserve the life of the mother.
14. Charges for services provided by a Social Worker, except as shown as a covered expense.
15. Hospital charges that are incurred prior to the first Monday of a confinement that begins on a Friday, Saturday or Sunday, unless:
 - a. Such confinement is due to a Medical Emergency; or
 - b. Surgery is performed within twenty-four (24) hours after such confinement begins.
16. Charges for over-the-counter birth control drugs and contraceptive devices.
17. Charges for nutritional supplements, vitamins or minerals.
18. Services or supplies for the purpose of nicotine cessation, unless otherwise stated herein.
19. Charges for any of the following items, including their prescription or fitting, except as shown as a covered expense:
 - a. Hearing aids or cochlear implants;
 - b. Optical or visual aids, including contact lenses and eyeglasses;

- c. Wigs and hair transplants;
 - d. Orthopedic shoes;
 - e. Any examination to determine the need for, or the proper adjustments of any item listed above; and
 - f. Any procedure or surgical procedure to correct refractive error, except for Laser Keratomileusis, Conductive Keratoplasty, Corneal Relaxing Incision, and Corneal Wedge Resection providing the procedure is following a Corneal Transplant Surgery and treatment with spectacles and contact lenses will be unsuccessful in treating the visual disability.
- 20. Charges for testing, training or rehabilitation for educational, developmental or vocational purposes.
 - 21. Charges for marriage counseling and/or sexual therapy.
 - 22. Charges for care, treatment, surgery, services or supplies that are primarily for obesity, weight reduction or dietary control, including but not limited to vitamins, diet supplements or enrollment in health, athletic or similar clubs or exercise programs, whether formal or informal and whether or not recommended by a Physician, or complications thereof.
 - 23. Charges for treatment of a learning disability.
 - 24. Assistant surgeon and co-surgeon services related to podiatry surgery.
 - 25. Foot care resulting from:
 - a. Weak, strained, unstable, unbalanced or flat feet;
 - b. Metatarsalgia or bunions, unless an open cutting operation is performed; or
 - c. Treatment of corns, calluses or toenails, unless at least part of the nail root is removed or care is necessary for metabolic or peripheral vascular disease; or
 - d. Supportive devices (orthotics) for such conditions.
 - 26. The care and treatment of the teeth, gums or alveolar process, and dentures, appliances or supplies used in such care and treatment, except as shown as covered expenses.
 - 27. Treatment of temporomandibular joint (TMJ) dysfunction with intraoral prosthetic devices, or any other method to alter vertical dimension.
 - 28. Services for sex transformations or services for sexual dysfunctions which are not related to an organic disease including, but not limited to, surgery, implants or related hormone treatment.
 - 29. Travel for health, unless otherwise stated herein.
 - 30. Routine or periodic health examinations or immunizations except as shown as a covered expense.
 - 31. Charges for chelation (metallic ion) therapy.
 - 32. Any item shown in General Exclusions and Limitations.

DENTAL EXPENSE BENEFIT

The Dental Expense Benefit has been designed to help you pay for your family's dental expenses and orthodontic treatment. This benefit covers only those dental expenses which are performed by a licensed Dentist or by a licensed Dental Hygienist if rendered under the supervision and guidance of a Dentist.

Covered dental expenses are further limited to those services and supplies customarily employed for treatment of dental conditions only if rendered in accordance with accepted standards of dental practice.

This benefit covers the services included in the List of Covered Services, appearing on later pages. The list is divided into Preventive, Basic, Major and Orthodontic services.

If a dental service is performed that is not on the list and the service is not excluded by this Plan, but the list contains a similar service that is suitable for the condition being treated, then benefits will be payable as if the listed service was the one actually performed.

A charge will be considered to be incurred:

- ◆ For dentures or partials - on the date the impression is taken;
- ◆ For fixed bridgework, crowns, inlays or onlays - on the date the tooth or teeth are prepared and the final impressions are made;
- ◆ For root canal therapy - on the date the pulp chamber is opened and explored; and
- ◆ For all other services - on the date the service is performed.

DEDUCTIBLE AMOUNT

The Dental Deductible, if applicable, is the amount of Covered Dental Expenses which you must pay before benefits are payable by the Plan. The Dental Deductible is shown on the Schedule of Benefits and must be satisfied each Calendar Year.

FAMILY DEDUCTIBLE

When Covered Family Members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Dental Deductibles to the remaining Covered Dental Expenses for all Covered Family Members for that Calendar Year.

CO-INSURANCE FACTOR

After the Calendar Year Deductible is satisfied, the Plan will pay benefits at the applicable co-insurance percentage shown on the Schedule of Benefits for all eligible Dental Expenses incurred by that individual during the remainder of that Calendar Year.

CALENDAR YEAR MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to you and to each of your Covered Dependents for all dental services, not including orthodontic services, received in any one Calendar Year.

ALTERNATE TREATMENT PLANS

In all cases in which there are alternate plans of treatment carrying different treatment costs, payment will be made only for the least expensive procedure which will produce a professionally satisfactory result, with the balance of the treatment cost remaining the responsibility of the patient.

TREATMENT PLAN

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of \$500 or more, a description of the procedures to be performed and an estimate of the Dentist's charges should be filed with the Claims Administrator before beginning dental care.

Many Dentists require that you agree to the proposed treatment and charges before treatment begins. Therefore, it is valuable for you to know what the Dental benefit will pay before you make a financial commitment.

Have the Dentist complete the dental claim form including a written description of the proposed treatment, the estimated cost and x-rays. This process allows the Claims Administrator the opportunity to review Plan specifications such as deductibles, co-insurance percentages, benefit maximums, limitations and exclusions.

The Claims Administrator will notify the Dentist of the benefits payable. Consideration will be given to alternate procedures, services or courses of treatment that may be performed in order to accomplish the desired result.

If a Treatment Plan is not submitted in advance, the Claims Administrator reserves the right to make a determination of benefits payable considering alternate procedures, services, or courses of treatment, based on accepted standards of dental practice.

This Treatment Plan requirement will not apply to courses of treatment under \$500 or to emergency treatment, routine oral examination x-rays, prophylaxis and fluoride treatments.

ORTHODONTIC EXPENSE BENEFIT

DEPENDENT CHILD COVERAGE ONLY (Under age 19)

When your Covered Dependent Child incurs expenses on the accompanying "List of Covered Orthodontic Services" and such expense is incurred while this coverage is in force for your Dependent Child and treatment is rendered by a Dentist as defined herein, the Plan will pay the benefits as determined for the reasonable charges actually incurred.

ORTHODONTIC PROCEDURE

Orthodontic procedures means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

ORTHODONTIC TREATMENT PLAN

The charges must be a part of an Orthodontic Treatment Plan which, prior to the performance of the procedures, has been (a) submitted to the Claims Administrator and (b) reviewed and returned to the Dentist showing estimated benefits. Submission of an Orthodontic Treatment Plan is not required if charges made or to be made total \$500 or less. Such Treatment Plan must:

1. Provide a classification of the malocclusion,
2. Recommend and describe necessary treatment by orthodontic procedures,
3. Estimate the duration over which treatment will be completed,
4. Estimate the total charge for such treatment, and
5. Be accompanied by cephalometric x-rays, study models and such other supporting evidence as the Claims Administrator may reasonably require.

COVERED CHARGES

The total covered charges scheduled to be made in accordance with an Orthodontic Treatment Plan shall be payable in equal quarterly installments over a period of time equal to the estimated duration of the Orthodontic Treatment Plan; however, the number of quarterly installments shall not exceed eight (8). The first installment shall become payable on the date on which the orthodontic appliances were first installed, and subsequent installments shall become payable at the end of each three- month period thereafter.

Charges are covered only to the extent that they are made in connection with an orthodontic procedure which is required by one or more of the following conditions:

1. Overbite or overjet of at least four (4) millimeters.
2. Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp.
3. Cross-bite.
4. An arch length discrepancy of more than four (4) millimeters in either the upper or lower arch.

LIFETIME ORTHODONTIC MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to each of your covered dependents for all Orthodontic benefits received in a lifetime.

LIMITATION

Orthodontic procedures must commence prior to a Covered Dependent child attaining age nineteen (19) and the first active appliance must be installed while the child is covered under this Plan.

COVERED SERVICES

PREVENTIVE SERVICES

Oral Examinations

Initial

Periodic

Initial and periodic exams are limited to one (1) per six (6) months

Emergency Oral Examination for the relief of dental pain

Prophylaxis with or without oral examination (limited to one (1) per six (6) months)

Topical application of stannous fluoride for individuals under age fourteen (14) (limited to one (1) in any six (6) month period)

X-Rays

Entire denture series consisting of at least 14 films, including bitewings, if necessary.

Single film -- Initial

Additional films (up to 12) each

Intraoral, occlusal view, maxillary or mandibular, each

Superior or inferior maxillary, extraoral, one film Bitewing films

Panoramic survey, maxillary and mandibular, single film (considered an entire denture series)

Space Maintainers

Limited to dependent children under the age of 16.

BASIC SERVICES

Non-Routine Visits

Consultation by other than practitioner providing treatment

Office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures)

Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)

Pathology -- Except for injuries covered charge includes examination and diagnosis

Bacteriologic studies

Carries susceptibility tests

Biopsy and examination of oral tissue Pulp vitality tests

Diagnostic casts

Oral Surgery -- Includes local anesthesia and routine post-operative care

Extractions

Uncomplicated (single)

Surgical removal of erupted tooth (including tissue flap and bone removal)

Post-operative visit (sutures and complications) after multiple extractions of impactions

Impacted Teeth

Removal of tooth (soft tissue)

Removal of tooth (partially bony)

Removal of tooth (completely bony)

Alveolar Or Gingival Reconstructions

Alveolectomy (in addition to removal of teeth) per quadrant

Alveolectomy (edentulous) per quadrant

Alveoloplasty with ridge extension, per arch

Excision of pericorneal gingiva, per tooth

Removal of palatal torus

Removal of mandibular tori, per quadrant

Excision of hyperplastic tissue, per arch

Cysts And Neoplasms

Removal of cyst or tumor

Other Surgical Procedures

Closure of oral fistula of maxillary sinus

Replantation of tooth or tooth bud

Crown exposure for orthodontia

Incision and drainage of abscess

Removal of foreign body from soft tissue

Removal of foreign body from bone (independent procedure)

Sequestrectomy for osteomyelitis for bone abscess, superficial

Maxillary sinusotomy for removal of tooth fragment or foreign body

Suture of soft tissue injury

Sialolithotomy; removal of salivary calculus

Closure of salivary fistula

Dilation of salivary duct

Anesthesia

General, in conjunction with surgical procedures only

Periodontics -- Includes post surgical visits

Gingivectomy (including post-surgical visits) per quadrant

Gingivectomy, treatment per tooth (fewer than six teeth)

Subgingival curettage, root planning, per quadrant, maximum of four quadrants within twelve consecutive months (not prophylaxis)

Osseous surgery (including post-surgical visits) per quadrant

Muco gingival surgery (pedicle soft tissue graft, sliding horizontal flap)

Occlusal adjustment, performed in conjunction with Periodontal surgery, per quadrant, maximum of four quadrants within twelve consecutive months

Endodontics

Pulp capping - direct, excluding final restoration

Vital pulpotomy, excluding final restoration

Apicoectomy (performed as a separate surgical procedure)

Apicoectomy (performed in conjunction with endodontic procedure)

Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only

Root Canals -- Treatment of non-vital teeth. Allowances include necessary x-rays and cultures but exclude final restoration

Anterior Teeth

Medicated paste - (N-2)

Traditional canal therapy

Bicuspid Teeth

Medicated paste - (N-2)

Traditional canal therapy

Molar Teeth

Medicated paste - (N-2)

Traditional canal therapy

Amalgam Restorations – Primary Teeth

Cavities involving one surface

Cavities involving two surfaces

Cavities involving three or more surfaces

Amalgam Restorations - Permanent Teeth

Cavities involving one surface

Cavities involving two surfaces

Cavities involving three or more surfaces

Synthetic Restorations

Silicate cement filling

Acrylic or Plastic filling

Composite resin involving one surface

Composite resin involving three or more surfaces

MAJOR SERVICES

Pins

Pin retention – exclusive of restorative material (used in lieu of cast restoration) -- indicate number of pins

Crown

Stainless steel (when tooth cannot be restored with a filling material)

Full And Partial Denture Repairs

Broken dentures, no teeth involved

Partial denture repairs (metal) Covered charge based upon extent and nature of damage and type of materials involved. Replacing missing or broken teeth, each tooth

Repairs, Crown And Bridges

Repairs (Covered charge based upon extent and nature of damage and type of materials involved)

Adding Teeth To Partial Denture To Replace Extracted Natural Teeth

First tooth

Each additional tooth and clasp

Recementation

Inlay

Crown

Bridge

Denture Relinings And Rebastings -- Allowable after six months from installation of appliance

Upper denture duplication (jump case) per denture (limited to once in a period of 36 consecutive months)

Lower denture duplication (jump case) per denture (limited to once in a period of 36 consecutive months)

Upper denture reline (includes full and partial), office, cold cure (limited to once in a period of 12 consecutive months)

Lower denture reline (includes full and partial), office, cold cure (limited to once in a period of 12 consecutive months)

Upper denture reline (includes full and partial), laboratory (limited to once in a period of 12 consecutive months)

Lower denture reline (includes full and partial), laboratory (limited to once in a period of 12 consecutive months)

Tissue conditioning, per denture (maximum of two treatments per arch) (limited to once in a period of 12 consecutive months). Indicate whether upper or lower

Denture Adjustments

Adjustment to denture more than six months after installation of it by other than Dentist providing appliance

Restorative –Cast restorations and crowns are covered only by decay or traumatic injury and the tooth cannot be restored with routine filling material

Inlays

One surface

Two surfaces

Three or more surfaces

Onlay, in addition to inlay allowance

Crowns

Acrylic, Acrylic with gold

Acrylic with semi-precious metal

Porcelain

Porcelain with gold

Porcelain with semi-precious metal

Gold (full cast)

Full cast with semi-precious metal

Gold (3/4 cast)

Cast post and core (in addition to crown), separate

Steel post and composite or amalgam (in addition to crown)

Cast dowel pin (one-piece casting with crown) Indicate type of crown

Prosthodontics

Bridge Abutments (See Inlays and Crowns)

Pontics

Cast gold (sanitary)

Cast with semi-precious metal (sanitary)

Slotted facing

Slotted pontic

Porcelain fused to gold

Porcelain fused to semi-precious metal

Plastic processed to gold

Plastic processed to semi-precious metal

Removable Bridge (unilateral)

One piece chrome casting clasp attachment (all types), per unit including pontics

Dentures And Partial Dentures-- Covered charges for dentures and partial dentures include adjustments and relines within six months after installation. Specialized techniques and characterizations are not covered.

Complete maxillary denture

Complete mandibular denture

Upper partial, with two chrome clasps with rests, acrylic base

Lower partial with two chrome clasps with rests, acrylic base

Lower partial with chrome lingual bar and clasps, acrylic base

Upper partial with chrome lingual bar and clasps, acrylic base

Stayplate base, temporary denture (anterior teeth only) Indicate whether upper or lower)

Simple stress breakers, extra per unit

ORTHODONTIC SERVICES

Preventive Treatment Procedures

Radiographs

Cephalometric film

Minor treatment for tooth guidance

Interceptive Orthodontic Treatment

Removal appliance therapy

Fixed appliance therapy

Treatment of the Transitional Dentition

Class I Malocclusion

Class II Malocclusion

Class III Malocclusion

Treatment of the Permanent Dentition

Class I Malocclusion

Class II Malocclusion

Class III Malocclusion

DENTAL EXPENSE EXCLUSIONS AND LIMITATIONS

The Dental Benefit provisions of this Plan do not cover any loss caused by, incurred for, or resulting from:

1. A service furnished a Covered Person for:
 - a. Cosmetic purposes, unless necessitated as a result of accidental injuries sustained while such person was covered under this Plan and for the repair of which the service is furnished within one (1) year of the date of the accident and while the individual remains a Covered Person. For purposes of this limitation, facings on crowns or pontics posterior to the second bicuspid and the personalization and characterization of dentures shall always be considered cosmetic;
 - b. Dental care of a congenital or developmental malformation (unless an Orthodontic Benefit provision is specifically included and made a part of this Plan).
2. An orthodontic service, unless specifically provided by an Orthodontic Benefit provision included in and made a part of this Plan.
3. Replacement of lost, missing or stolen prosthetic device or any other device or appliance.
4. Replacement of lost, missing or stolen orthodontic appliances.
5. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, replacing tooth structure lost as a result of abrasion or attrition or treatment of disturbances of the temporomandibular joint.
6. A service not reasonably necessary or not customarily performed for the dental care of the Covered Person.
7. A service not furnished by a Dentist, unless the service is performed by a licensed Dental Hygienist under the supervision of a Dentist or an x-ray ordered by a Dentist.
8. Sealants, oral hygiene instruction, a plaque control program or dietary instructions.
9. Implantology.
10. The initial placement of a partial or full removable denture or fixed bridgework, including crowns and inlays forming the abutments, if involving the replacement of one or more natural teeth extracted prior to the Covered Person becoming covered under this Plan, unless the denture or fixed bridgework also includes the replacement of a natural tooth which is extracted while the Covered Person is covered under this Plan.
11. The replacement of a removable partial or denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, is covered only due to one of the following:

- a. The replacement or addition of teeth is required to replace one or more natural teeth extracted while covered under this Plan.
 - b. The existing denture or bridgework was installed at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable.
 - c. An accidental bodily injury sustained while the Covered Person is covered under this Plan.
- 12. Any dental services or supplies which are included as covered expenses under any other provision in this Plan, or under any other group plan carried or sponsored by the Company.
 - 13. Services or supplies that do not meet accepted standards of dental practice including, but not limited to, services which are investigational or experimental in nature.
 - 14. Services or supplies of the type normally intended for sport or home use such as athletic mouth guards, toothpaste, toothbrushes, etc.
 - 15. Any item shown in General Exclusions or Limitations.

EXTENSION OF BENEFITS

No payment will be made under the Plan for dental services or supplies furnished on or after the date of termination of your or your dependent's coverage, except under the following specified circumstances:

1. In the case of appliances or modification of appliances not related to Orthodontic Treatment; if the master impression was taken by a Dentist while coverage was in effect under this Plan, benefits will be payable if the appliance was delivered or installed within sixty (60) days after the termination of coverage.
2. In the case of a crown, bridge or inlay or onlay restoration; if the tooth or teeth were prepared while coverage was in effect under this Plan, benefits will be payable if such crown, bridge or cast restoration was installed within sixty (60) days after the termination of coverage.
3. In the case of root canal therapy; if the pulp chamber was opened while coverage was in effect under this Plan, benefits will be payable if such root canal therapy is completed within sixty (60) days after the termination of coverage.
4. In the case of Orthodontic Treatment commencing while coverage was in effect under this Plan; benefits will be payable through the end of the month in which coverage terminated, based on a proration of the applicable quarterly installment.

The above benefits are subject to all other conditions, limitations, and exclusions contained in this Plan.

VISION CARE EXPENSE BENEFIT

The Vision Expense Benefit has been designed to provide reimbursement for the expenses incurred for the cost of vision examinations, lenses, and frames prescribed by a legally qualified Ophthalmologist or Optometrist.

COVERED EXPENSES

Covered charges include the following services or supplies and are payable as shown on the Schedule of Benefits:

Vision Examination

- ♦ The examination may include an ocular case history, external examination, ophthalmoscopic examination, refraction, binocular measure, tonometry, or any other medically necessary vision test, prescription for corrective lenses when indicated, summary and findings, and inspection of any corrective lenses prescribed.

Lenses

- ♦ Single Vision Lenses
- ♦ Bifocal or equivalent progressive lenses
- ♦ Trifocal or equivalent progressive lenses
- ♦ Lenticular lenses
- ♦ Contact lenses
- ♦ Prescription Sunglasses

Frames

VISION CARE EXCLUSIONS AND LIMITATIONS

The Vision Benefit provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

1. Vision care expenses incurred which were not recommended and approved by a licensed Optometrist or Ophthalmologist.
2. Any medical or surgical treatment or supplies (including prosthetic devices) furnished for surgical or medical care for the treatment of an eye disease and/or injury.
3. Sunglasses without a prescription, and charges for tinting and anti-reflective coatings.
4. Non-prescription lenses of any kind.
5. Replacement, at other than the normal policy period, of lenses or frames which were furnished under this Plan and which have been lost, stolen, or broken.
6. Duplicate or spare-eyeglasses or lenses or frames.
7. Orthoptics (eye muscle exercises).
8. Subnormal vision aids, such as ocular microscopes, ocular telescopes or hand-held magnifiers.
9. Any item shown in General Exclusions and Limitations.

GENERAL EXCLUSIONS AND LIMITATIONS

This Plan does not cover and no benefits shall be paid for any loss caused by, incurred for or resulting from:

1. Charges in excess of Reasonable and Customary fees.
2. Services or supplies received from either an Employee's or Employee's spouse's relative, any individual who ordinarily resides in the Employee's home or any such similar person.
3. Charges for failure to keep a scheduled visit or charges for completion of a claim form or for medical records.
4. Charges for telephone conversations or skype/face-time conversations.
5. Services or supplies for which there is no legal obligation to pay or for which no charge would be made in the absence of this coverage.
6. Charges for or in connection with an illness or injury for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupation Disease Law or similar Local, State or Federal Statutes under which the Covered Person is entitled to benefits.
7. Charges for or in connection with an injury or illness arising out of or in the course of war, declared or undeclared, service in any military, naval, or air force of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces.
8. Services or supplies that are provided by the local, state or federal government and that part of the charges for any services or supplies for which payment is provided or available from the local, state or federal government (i.e., Medicare) whether or not that payment is received, except as otherwise provided by law.
9. Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are experimental or investigational in nature.
10. Charges for or in connection with an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a crime or felony.
11. Services or supplies furnished by a hospital owned or operated by the United States Government or agency thereof, or furnished by a physician employed by the United States Government or agency thereof, to the extent permitted by law.
12. Charges incurred outside the United States if:
 - a. The Covered Person traveled to such location to obtain medical services, drugs or supplies; or
 - b. Such services, drugs or supplies are unavailable or illegal in the United States.

13. Charges for services required by any employer as a condition of employment, or rendered through a medical department, clinic or other similar facility provided by an employer or by a union employee benefit association or similar group of which the person is a member.
14. Health examinations required for the use of a third party.
15. Treatment of any condition not caused by illness or not resulting from bodily injury, except as shown as a covered expense.
16. Expenses submitted more than twelve (12) months after the date incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.
17. Charges in excess of the benefits specified in this Plan.

OTHER HEALTH BENEFIT PLAN INFORMATION

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Worker's compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Allowable Expenses.

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Participant does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO Provider.

Claim Determination Period

“Claim Determination Period” shall mean each calendar year.

Effect on Benefits:

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the

stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the section below, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").
2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Plan Participant(s) fails to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party;
 - b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. Any policy of insurance from any insurance company or guarantor of a third party;
 - d. Worker's compensation or other liability insurance company; or
 - e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- a. The responsible party, its insurer, or any other source on behalf of that party;
- b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. Any policy of insurance from any insurance company or guarantor of a third party;
- d. Worker's compensation or other liability insurance company; or
- e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

- e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
 3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MEDICARE PROVISIONS

Medicare means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 or as later amended.

Full Medicare Coverage means coverage for all the benefits provided under Medicare including benefits provided under the voluntary program (Medicare Part B - doctor's portion) established by Medicare.

Medical Charges as used in this Provision with respect to any services, treatments or supplies, means the charges actually made for such services, treatments or supplies to the extent reasonable and customary.

ACTIVE EMPLOYEES AGE SIXTY-FIVE (65) OR OVER

For active employees age sixty-five (65) or over who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage would provide supplemental benefits for those expenses not paid by this Plan.

If the active employee's spouse is also enrolled in this Plan, this provision would apply to the spouse during the period of time the spouse is sixty-five (65) or over, regardless of the age of the employee.

This provision does not apply to individuals entitled to Medicare because of end stage renal disease (ESRD) and/or disability.

This provision intends to comply with the TEFRA Act of 1982, the DEFRA Act of 1985, the COBRA Act of 1985 and the OMBRA Act of 1986 and all similar Federal acts.

CERTAIN DISABLED INDIVIDUALS

(Employers with 100 or more Employees)

This Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for disabled individuals who are "currently working" (as defined by Medicare) covered employees or covered dependents of such employees.

Effective August 10, 1993, Medicare will be the primary payor and this Plan will be the secondary payor for the payment of benefits for disabled individuals who are not "currently working" (as defined by Medicare) covered employees or covered dependents of such employees. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

This provision does not apply to "currently working" disabled individuals entitled to Medicare because of end stage renal disease (ESRD) during the period of time which Medicare is the primary payor and the Plan is the secondary payor as prescribed by law. This provision intends to comply with the OMBRA Act of 1986 and 1993.

CERTAIN DISABLED INDIVIDUALS

(Employers with less than 100 Employees)

For covered individuals who are totally disabled who are eligible for Medicare benefits, both Medicare Part A (hospital portion) and Medicare Part B (doctors portion) will be considered the primary payor in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

INDIVIDUALS WITH END STAGE RENAL DISEASE

For covered individuals with end stage renal disease (ESRD) who are eligible for Medicare benefits, this Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for the period of time specified by law, after which time Medicare will become the primary payor and this Plan will be the secondary payor. Both Medicare Part A (hospital portion) and Medicare Part B (doctors portion) will be considered in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred. This provision intends to comply with the OMBRA Act of 1993.

RETIRED INDIVIDUALS AND THEIR COVERED DEPENDENTS

For covered retired individuals who are eligible for Medicare benefits, both Medicare Part A (hospital portion) and Medicare Part B (doctors portion) will be considered in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

***Note:* These Medicare Provisions Apply From The Date The Covered Individual Is First Eligible For Medicare Coverage (Either Part A - Hospital Coverage Or Part B - Physician Coverage) Whether Or Not The Covered Individual Is Enrolled And Is Receiving Medicare Benefits.**

COBRA

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This information is included as part of the Plan Document/Summary Plan Description. For additional information about your rights and obligations under the Plan and under the federal law, you should contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “Qualifying Event”. Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a “Qualified Beneficiary”. You, your spouse and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the Employee and Employer cost of coverage) before the group health coverage is continued **and** monthly payments must be made in order to continue the coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment end for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title eleven (11) of the United States Code can be a Qualifying Event, but only if the Plan offers retiree coverage. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or the reduction of hours of employment, death of employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee becoming entitled to Medicare benefits (Part A, Part B or both), the Employer must notify the Plan Administrator within thirty (30) days of any of these events.

You Must Give Notice Of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within sixty (60) days after the Qualifying Event occurs. Your written notice should include the date of the Qualifying Event. If you or your spouse are notifying the Plan Administrator of a divorce or legal separation, you or your spouse should provide a copy of the legal separation papers or divorce decree. You must provide this notice to: **JACKSON COUNTY GOVERNMENT**.

If you fail to give written notice with the sixty (60) day time period, the spouse and/or dependent child shall lose the right to elect COBRA continuation coverage.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, your divorce or legal separation, a dependent child's losing eligibility as a dependent or loss of coverage due to Medicare Entitlement (under Part A, Part B or both), COBRA continuation lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension Of The Eighteen (18) Month Period

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started some time before the sixtieth (60th) day of COBRA continuation coverage and last at least until the end of the eighteen (18) month period of COBRA continuation coverage. A copy of the Notice of Award from the Social Security Administration must be submitted to the Plan Administrator and the COBRA Administrator within sixty (60) days of receipt of Notice of Award and before the end of the eighteen (18) month period of COBRA continuation coverage.

Second Qualifying Event Extension Of Eighteen (18) Month Period

If your COBRA covered family members experience another COBRA Qualifying Event within the first eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family may be eligible to receive up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the secondary event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, or is divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. In all cases, the eighteen (18) month extension is available only if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

The following example shows how the second Qualifying Event rule works. Former employee A elects eighteen (18) months of COBRA continuation coverage for the entire family. After the first six (6) months of COBRA continuation coverage, former employee A becomes entitled to Medicare (Part A, Part B or both). If former employee A were still actively employed, entitlement to Medicare **would not**

result in a loss of coverage under the Employer's group health plan. The additional eighteen (18) month extension is not available for the former employee's spouse and dependents because if Medicare entitlement had occurred during active employment there would have been no loss of Employer group health plan coverage.

In all of these cases, you must notify the Plan Administrator within sixty (60) days of the second Qualifying Event.

Early Termination Of COBRA Continuation Coverage

COBRA continuation coverage will terminate before the end of the maximum period if:

- The Qualified Beneficiary fails to make the required contributions when due;
- The Qualified Beneficiary becomes covered under another group health plan after the date of the COBRA election, unless the new group coverage is limited due to a pre-existing condition exclusion. COBRA continuation coverage will be the primary payor for the pre-existing condition and secondary payor for all other eligible health care expenses;
- The Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both) after electing COBRA continuation coverage; or
- The Employer ceases to provide any group health plan for its employees.

How Can You Elect COBRA Continuation Coverage?

To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several or for all dependent children who are Qualified Beneficiaries. A parent may elect to continue COBRA continuation coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA continuation coverage on behalf of all of the Qualified Beneficiaries.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage and election of COBRA continuation coverage may help you not have such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect COBRA continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

How Much Does COBRA Continuation Coverage COST?

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of COBRA continuation coverage due to a disability, one hundred fifty percent (150%)) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. The required payment for each COBRA continuation coverage period for each option is described in this notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or receive advance payment of sixty-five percent (65%) of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact.

When and How Must Payment for COBRA Continuation Coverage be Made?

First Payment For COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage not later than forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator or Plan Administrator to confirm the correct amount of your first payment.

Periodic Payments For COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each Qualified Beneficiary is shown on the Election Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace Periods For Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to the Plan Administrator or COBRA Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation rights should be addressed to the contact identified below. For more information about your rights including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed

In order to protect your family's rights, you should keep the Plan Administrator informed of any change in marital status, dependent status or address change. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Jackson County Government
Jackson County Board Office
1001 Walnut Street
Murphysboro, IL 62966
(618) 687-7240

DEFINITIONS OF TERMS

The terms are capitalized to highlight their use.

ACCIDENT - An injury which is:

1. Caused by an event which is sudden and unforeseen; and
2. Exact as to time and place of occurrence.

ADVERSE BENEFIT DETERMINATION – A denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, or to provide or make payment that is based on a determination of participant's or beneficiary's eligibility to participate in a plan, with respect to group health plans. Included is failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage is also an adverse benefit determination.

ALCOHOL, CHEMICAL DEPENDENCY OR DRUG ADDICTION TREATMENT FACILITY - A facility (other than a hospital) whose primary function is the treatment of alcoholism, chemical dependency or drug addiction and which is approved by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or is duly licensed by the appropriate governmental authority to provide such services.

ALTERNATE RECIPIENT – Any child of a participant who is recognized under a medical child support order as having a right to enrollment under a Group Health Plan. A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

AMBULANCE - Emergency transportation in a specially equipped certified vehicle from the Covered Person's home, the scene of an accident or a medical emergency to a hospital, between hospitals, between a hospital and an extended care facility or from a hospital or an extended care facility to the Covered Person's home.

AMBULATORY SURGICAL CENTER - A specialized facility or a facility affiliated with a Hospital which is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or licensed in accordance with the applicable laws in the jurisdiction in which it is located and is established, equipped and operated primarily for the purpose of performing surgical procedures on an ambulatory basis.

APPLICABLE PREMIUM - The cost to the Plan for the continuation coverage.

ASSIGNMENT OF BENEFITS - Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a

written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

BENEFICIARY - The person named to receive the Covered Person's Life Insurance Benefit and/or Accidental Death Benefit, or any person or persons (including but not limited to, an individual, trust, estate, executor, administrator or fiduciary, whether corporate or otherwise) designated to receive benefits pursuant to the terms of the Plan or any insurance policies, contracts or administrative service agreements, constituting the Plan.

BIRTHING CENTER - A specialized facility or a facility affiliated with a hospital which:

1. Provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives; and
2. Is staffed, equipped and operated to provide:
 - a. Care for patients during uncomplicated pregnancy, delivery, and the immediate postpartum period;
 - b. Care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life; and
 - c. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

CALENDAR YEAR - For the purposes of this Plan, a length of time beginning on January 1 and ending on December 31.

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) - A person who:

1. Is a graduate of an approved school of nursing and is duly licensed as a registered nurse;
2. Is a graduate of an approved program of nurse anesthesia accredited by the Council of Certification of Nurse Anesthetists or its predecessors;
3. Has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and
4. Is recertified every two (2) years by the Council on Recertification of Nurse Anesthetists.

CHILD - The Employee's Children under twenty-six (26) years of age (or under age thirty (30), if an unmarried military veteran residing in Illinois). The term "Child" shall include natural Children, a legally adopted Child (including the period of probation when the Child is placed with the adopting parents), a step-Child, a Child related to the Employee by blood or marriage and for whom the Employee has assumed legal guardianship, or a Child whom the Employee must cover due to a Qualified Medical Child Support Order (QMCSO), subject to the conditions and limits of the law.

An unmarried Child who is physically or mentally incapable of self-support upon attaining age twenty-six (26), may be covered under the health care benefits, while remaining incapacitated, subject to the Covered Employee's own coverage continuing in effect. Such Child will be considered a Covered Dependent if he was Disabled prior to his twenty-sixth (26th) birthday.

To continue Covered Dependent status of a child under this provision, proof of incapacity must be received by the Company within thirty-one (31) days after coverage would otherwise terminate. Additional proof will be required from time to time.

Evidence satisfactory to the Company of dependent eligibility under the Plan may be requested; for example, birth records or Federal Income Tax returns.

CIVIL UNION PARTNER – The person who has entered into a legally granted Civil Union with the Employee while the Employee is covered under this Plan.

CLAIMS ADMINISTRATOR – Benefit Administrative Systems, LLC

CODE - The Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder.

CO-INSURANCE - That portion of Covered Medical Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the deductible which are to be paid by the Employee.

COMPANY – Jackson County Government

CONTINUATION PREMIUM - The amount charged by the Plan to a Qualified Beneficiary for a specified period of continuation coverage under the Plan.

COORDINATION OF BENEFITS - If an individual is covered by another group plan of health care, this Plan will coordinate its payment of benefits with the other plan to allow as complete a claim reimbursement as possible without providing duplicate payments. See the Coordination of Benefits section of the Plan.

CO-PAYMENT - That portion of Covered Medical Expenses which must be paid by or on behalf of the Covered Person incurring the expense.

COSMETIC SURGERY - Surgery that is intended to improve the appearance of a patient or preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body. This does not include reconstructive surgery resulting from an Illness or Injury.

COVERED EMPLOYEE - An Employee who has satisfied all applicable Eligibility provisions of the Plan and for whom coverage has not terminated.

COVERED PERSON - A Covered Employee or Covered Dependent as herein described.

CUSTODIAL CARE - Care which is not a necessary part of medical treatment for recovery but provides services and support to assist the Covered Person in the activities of daily living including, but not limited to, walking, bathing or feeding. It also consists of care which any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respirations; suctioning of the pharynx; administering and monitoring feeding systems or drugs and medicines which are usually self-administered.

DEDUCTIBLE - The amount of Covered Medical and/or Dental Expenses that a Covered Person must pay before he can receive a benefit payment under the Medical and/or Dental Expense Benefits.

DENTIST - A duly licensed Dentist practicing within the scope of his license and any other Physician furnishing any dental services which he is licensed to perform.

DENTAL HYGIENIST - A person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of Dental Hygiene, and who works under the direct supervision and direction of a Dentist.

DEPENDENT - For the purposes of this Plan, the Employee's Spouse, Civil Union Partner and Children (see definition of "Child"), and Disabled Children, if such incapacity occurred prior to the limiting age specified.

DIALYSIS FACILITY - A facility (other than a Hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DISABLED –

1. The Covered Person's complete inability as an active employee, to perform any and every duty pertaining to his occupation or employment or for any occupation for wage or profit, or
2. The Covered Dependent's complete inability to perform the normal activities of a person of like age and sex, or
3. The Covered Person's complete inability, as a retired employee, to perform the normal activities of a person of like age and sex.

DURABLE MEDICAL EQUIPMENT - Only that equipment and those supplies that:

1. Are primarily and customarily used to serve a medical purpose;
2. Would not be generally useful to a person in the absence of an Illness or Injury;

3. Are designed for repeated use; and
4. Either:
 - a. Are medically necessary to:
 - i. Treat an Illness or Injury;
 - ii. Effect improvement of a Covered Person's medical condition; or
 - iii. Arrest or retard deterioration of a Covered Person's medical condition; or
 - b. Are alternatives to chair or bed confinement.

ELECTIVE SURGERY - Surgery that is not emergency in nature or is not performed to correct a life-threatening situation.

EMERGENCY DENTAL CARE - An urgent, unplanned diagnostic visit and/or alleviation of acute or unexpected Dental condition.

EMERGENCY MEDICAL CARE - The initial treatment, including necessary related diagnostic services, of the unexpected and sudden onset of a medical condition manifesting itself by symptoms severe enough that the absence of immediate treatment could result in serious and/or permanent medical consequences.

EMERGENCY SERVICES - Emergency Services shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

EMPLOYEE - The word "Employee" as used herein shall mean any person employed and compensated for services by the Company on a regular full-time permanent basis who is regularly scheduled to work thirty (30) hours or more per week.

ESSENTIAL HEALTH BENEFITS - Essential Health Benefits shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXPERIMENTAL - The use of any treatment, procedure, facility, equipment, drug, device or supply which is not accepted as standard medical treatment of the condition being treated, or any such items requiring Federal or other government approval which has not been granted at the time services are rendered. In determining if any treatment, procedure, facility, equipment, drug, device or supply is experimental, the Plan Administrator may consider the views of the state or national medical communities and the views and practices of Medicare, Medicaid and other government financed programs. Although a Physician may have prescribed treatment, such treatment may still be considered Experimental by the Plan Administrator in its sole discretion within this definition.

Drug, Medical Tests, Procedures And Devices

Additional information regarding a specific drug, medical test, procedure or device, may be obtained free of charge by visiting www.benadmsys.com and accessing the section entitled “Medical Information Links”

EXTENDED CARE FACILITY (CONVALESCENT FACILITY) –

1. A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a hospital, as defined, or;
2. An institution which fully meets all of the following tests:
 - a. It is operated in accordance with the applicable laws of the appropriate governmental authority where it is located.
 - b. It is under the supervision of a licensed Physician, or Registered Nurse (R.N.), who is devoting full-time to such supervision.
 - c. It is regularly engaged in providing room and board and continuously provides twenty-four (24) hour-a-day skilled nursing care of ill and injured persons at the patient's expense during the convalescent stage of an injury or illness.
 - d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician.
 - e. It is authorized to administer medication on the order of a duly licensed Physician.
 - f. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

GENERIC DRUGS - Prescription drugs and prescription medicines which are not protected by a trademark.

GINA - the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

GROUP HEALTH PLAN - Any plan or arrangement constituting a group health plan.

HEALTH BENEFITS - Benefits provided under a Group Health Plan for medical care as defined pursuant to Section 213(d) of the Code.

HEALTH CARE PROFESSIONAL – A physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law.

HOME HEALTH AIDE - A person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY - Is either:

1. An Agency that is certified to participate as a Home Health Care Agency under Medicare;
2. A hospital that has a valid operating certificate and is certified by the appropriate authority to provide home health services;
3. An agency licensed as such, if such licensing is required, in the state in which such Home Health Care is delivered; or
4. A public agency or private organization or subdivision of such that meets the following requirements:
 - a. It is primarily engaged in providing nursing and other therapeutic services;
 - b. It is duly licensed, if such licensing is required, by the appropriate licensing authority, to provide such services;
 - c. It is federally certified as a Home Health Care Agency.

HOME HEALTH CARE PLAN - A Home Health Care program, prescribed in writing by a person's Physician, for the care and treatment of the person's Illness or Injury in the person's home. In the Plan, the Physician must certify that an inpatient stay in a Hospital, a Convalescent Nursing Home, or an Extended Care Facility would be required in the absence of the services and supplies provided as part of the Home Health Care Plan. The Home Health Care Plan must be established in writing no later than fourteen (14) days after the start of the Home Health Care. An inpatient stay is one for which a room and board charge is made.

HOSPICE CARE –

1. A coordinated, interdisciplinary Hospice-provided program meeting the physical, psychological, spiritual and social needs of dying individuals, and
2. Consists of palliative and supportive medical, nursing and other health services provided through home or inpatient care during the illness to a Covered Person who has no reasonable prospect of cure

and as estimated by a Physician, has a life expectancy of fewer than six (6) months; and consists of bereavement counseling for members of such Covered Person's immediate family.

HOSPICE CARE FACILITY - Is either:

1. A free-standing facility which is fully staffed and equipped to provide for the needs of the terminally ill (and their families); or
2. An inpatient facility which is part of a hospital but designated as a Hospice unit or is an adjacent facility, administered by a Hospital and designated as a Hospice unit.

A Hospice Care Facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or must meet the standards of the National Hospice Organization (NHO) and the appropriate licensing authority, if such licensing is required.

HOSPITAL - A legally operated institution which meets either of these tests:

1. Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
2. Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments under an in accordance with the provisions of Medicare, or
3. Is supervised by a staff of physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
 - a. General inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
 - b. Specialized inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
 - c. A psychiatric Hospital primarily engaged in diagnosing and treating mental illness, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
 - d. A free standing treatment facility, other than a Hospital, whose primary function is the treatment of alcoholism or drug abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service, and is accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Hospital Association.
 - e. A rehabilitative Hospital which is an institution operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, and which meets all of the requirements of an accredited Hospital.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

- a. Is primarily a facility for convalescence, nursing, rest, or the aged, or
- b. Furnishes primarily domiciliary or custodial care, including training in daily living routines, or
- c. Is operated primarily as a school.

ILLNESS - A bodily disorder, disease, pregnancy, or mental infirmity. All bodily injuries sustained by an individual in a single accident or all illnesses which are due to the same or related cause or causes will be deemed one illness.

INCURRED EXPENSE - A charge which the Covered Person is legally obligated to pay and shall be deemed to be incurred on the date the purchase is made or on the date the service is rendered for which the charge is made. Anticipated expenses are not incurred expenses.

INJURY - An unforeseen happening to the body, requiring medical attention, including all related symptoms and recurrent conditions resulting from the accident.

INPATIENT - A person receiving room and board while undergoing treatment in a Hospital, Hospice or other covered facility.

INTENSIVE CARE UNIT - A section, ward or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by professional nurses or other highly trained personnel, excluding any hospital facility maintained for the purposes of providing normal post-operative recovery treatment or services.

LEAVE OF ABSENCE - A period of time during which the employee does not work but which is of stated duration after which time the employee is expected to return to active full-time work.

LICENSED PRACTICAL NURSE/LICENSED VOCATIONAL NURSE - An individual who has received specialized nursing training and practical nursing experience and who is licensed to perform such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

LIFETIME - When used in reference to benefit maximums and limitations, "Lifetime" is understood to mean while covered under this Plan. Under no circumstances does "Lifetime" mean during the lifetime of the Covered Person.

MEDICAL EXPENSE BENEFIT - After satisfaction of the applicable deductible, benefits will be provided for covered medical expenses for an illness or injury in a calendar year.

MEDICALLY NECESSARY/MEDICAL NECESSITY - Services and supplies which are determined by the Plan Administrator, or its authorized agent to:

1. Be appropriate, consistent and necessary for the symptoms and diagnosis and treatment of a medical condition;

2. Be in accordance with standards of good medical practice within the organized medical community;
3. Not be solely for the convenience of the patient, Physician or other health care provider; and
4. Be the most appropriate and cost effective supply or level of service which can be safely provided. For hospitalizations, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate medical care cannot be received as an outpatient or in a less intensified medical setting.

The fact that the service is prescribed, ordered, recommended or approved by a Physician does not, of itself, mean the service is Medically Necessary. In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local Hospital practices, a Physician may suggest or permit a method of providing care that is not Medically Necessary.

MEDICARE - Title XVIII of the Social Security Act of 1965, as amended from time to time, and the regulations thereunder.

NETWORK PROVIDER - A health care provider who agrees to provide medically necessary care and treatment at a negotiated rate.

NOTICE OR NOTIFICATION – The ability to reasonably ensure actual receipt of the materials and specifically includes the normal mailing through the U. S. Mail.

OCCUPATIONAL THERAPY –Treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. Benefits are not provided for diversion, recreational and vocational therapies (such as hobbies, arts & crafts).

ORTHOTIC APPLIANCE – An external device intended to correct any defect in form or function of the human body.

OUT-OF-POCKET MAXIMUM - The maximum covered expense, in excess of the Deductible, that a Covered Person or family must pay before the Plan pays 100% of the balance of eligible medical expenses for such person or family for the remainder of the Calendar Year.

OUTPATIENT –When a Covered Person receives diagnosis, treatment or twenty-three (23) hour observation in a hospital or treatment facility but is not admitted as an inpatient.

PARTICIPANT - An Employee of the Plan Administrator who participates in the Plan.

PHARMACY - Any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPY –Treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound, manipulation and subluxation; as well as tests of measurement requirements to determine the need and progress of treatment. Such treatment must be

given to relieve pain, restore maximum function, and to prevent disability following illness, injury or loss of body parts. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other professional are required.

PHYSICIAN - A medical doctor (M.D.), an osteopath (D.O.), a dentist or dental surgeon (D.D.S., D.M.D.), a podiatrist (D.P.M.), a chiropractor (D.C.), a psychologist (Ph.D., Psy.D.) or an optometrist (D.O.) or other medical professional who is duly licensed under the laws of the appropriate governmental authority to practice medicine, to the extent they, within the scope of their license are permitted to perform the services provided by this Plan. (The term shall also include a Social Worker for the treatment of psychiatric disorders and substance abuse). A Physician shall not include the Covered Person or any close relative of the Covered Person.

PLAN - Jackson County Government Employee Health Care Plan.

PLAN ADMINISTRATOR –Jackson County Government, the entity responsible for the day to day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other services related to the Plan.

PLAN DOCUMENT - The legal document according to which the Plan is administered and governed.

PLAN YEAR - For purposes of this Plan, a length of time beginning on December 1st and ending on November 30th.

POST–SERVICE CLAIM – Any claim that involves only the payment or reimbursement of the cost for medical care that has already been provided.

PRE-ADMISSION TESTING - X-rays, laboratory examinations or other tests performed in the outpatient department of a hospital or other facility prior to outpatient treatment or to confinement as an inpatient provided:

1. Such tests are related to the scheduled hospital confinement;
2. Such tests have been ordered by a duly qualified physician after a condition requiring such confinement has been diagnosed and hospital admission has been requested by the physician, approved by the Utilization Review Service, and confirmed by the hospital; and
3. The Covered Person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable, or under the directions of the attending physician, or because there is a change in the patient's condition which precludes the confinement.

PREFERRED PROVIDER - A health care provider who agrees to provide medically necessary care and treatment at a negotiated rate under this Plan.

PREGNANCY –That physical state which results in childbirth, abortion or miscarriage, and any medical complications arising out of, or resulting from, such state.

PRE-SERVICE CLAIM – A claim that must be decided before a claimant will be afforded access to health care.

PROSTHETIC DEVICE –A device which:

1. Replaces all or part of a missing body organ and its adjoining tissue; or
2. Replaces all or part of the function of a permanently useless or malfunctioning organ.

PSYCHIATRIC DISORDER - Neuroses, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

PSYCHIATRIC TREATMENT - Treatment or care for:

1. A mental or emotional disease or disorder;
2. A functional nervous disorder; or
3. Psychological effects of Substance Abuse.

QUALIFIED BENEFICIARY - Any Beneficiary who is a qualified beneficiary.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) – A QMCSO is a medical child support order issued under State Law that creates or recognizes the existence of an “Alternate Recipient’s” right to receive benefits for which a participant or beneficiary is eligible under a group health plan.

Enrollment of a child may not be denied on the ground that:

1. The child was born out of wedlock;
2. The child is not claimed as a dependent on the participant’s Federal income tax return;
3. The child does not reside with the participant or in the plan’s services area; or
4. Because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, the Plan Administrator must enroll both the participant and the child(ren). All enrollments are to be made without regard to open season restrictions.

REASONABLE AND CUSTOMARY FEE LIMITATION - An amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar medical conditions in the locality concerned. The term "locality" means a county or such greater geographically significant area as is necessary to establish a representative cross section of persons, or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made.

REGISTERED NURSE - A professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

RELEVANT DOCUMENT – A document, record or other information that was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination (whether or not the information was relied upon to make a benefit determination); demonstrates compliance with the administrative process and safeguards required in making the benefit determination; or in the case of a group health or disability plan, information that constitutes a statement of policy with respect to the denied treatment option or benefit for the claimant's diagnosis.

RETIREE -

ROOM AND BOARD - Services regularly furnished by the Hospital as a condition of occupancy, but not including professional services.

SOUND NATURAL TOOTH - A tooth which:

1. Is free of decay, but may be restored by fillings;
2. Has a live root; and
3. Does not have a cap or a crown.

SPEECH THERAPY –Active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an illness or injury.

SPOUSE - The person who is legally married to the Employee while the Employee is covered under this Plan.

SUBSTANCE ABUSE - An excessive use of alcohol and/or drugs that results in physiological and/or psychological dependency of such substances.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) - Pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological conditions which create a loss or decrease of function in or around one or both of the jaw joints.

TERMINALLY ILL PATIENT - A person with a life expectancy of six (6) months or less as certified in writing by the attending physician.

TREATMENT PLAN - A Dentist's report, on a form satisfactory to the Company, which:

1. Itemizes the dental services recommended by him for the necessary and customary dental care of an Insured; and
2. Shows his charge for each dental service; and

3. Is accompanied by supporting pre-operative X-rays or other appropriate diagnostic materials as required by the Company.

URGENT CARE CLAIM – A claim for care that is needed if making a non-urgent care decision could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without treatment.

WORKERS' COMPENSATION - A fund administered under any Workers' Compensation, Occupational Diseases Act or Law or any other act or law of similar purpose to which the Company contributes, which provides the employee with coverage for job-related accidental injuries and illnesses.

HOW TO SUBMIT A CLAIM

GENERAL INFORMATION

To Receive Prompt And Full Payment For The Expenses Reimbursable Under This Plan, A Health Claim Form Must Be Completed During the Annual Enrollment Period.

Read the claim form carefully. Answer all of the questions on the form and include all required information.

The claim form has an "Authorization To Pay Benefits To Physician." This should be signed if you have NOT PAID the bill and you want payment made to the provider of service.

You should ALWAYS sign the "Authorization To Release Information".

Health claim forms are available from the Human Resources Department.

MEDICAL CLAIMS

Every medical claim must also include a Physician's statement specifying the nature of the illness or injury for which reimbursement is requested. The Claims Administrator will accept such a diagnostic statement on any form which your doctor prefers to use. ***WITHOUT A DIAGNOSIS, YOUR CLAIM CANNOT BE PROCESSED.***

All bills, except those for drugs, must indicate the patient's full name, the nature of the illness or injury, the date(s) of service, the type(s) of service and the charge for each service and the name, address and tax identification number of the provider.

For reimbursement of prescription drug expenses under the Medical Expense Benefit Plan, submit your bills indicating the patient's full name, the name of the prescribing physician, the prescription number and the name of the medication, the charge for each prescription and the date of each purchase.

When prescription drugs are purchased through the Prescription Drug Plan, a claim submission is not necessary. Your only responsibility is to pay the applicable co-payment at the time you purchase the prescription.

Should there be a primary insurance carrier for a member of your family, it is important to submit a copy of the itemized claim with a copy of the primary carrier's Explanation of Benefits statement indicating payment or denial of the charges.

MEDICARE CLAIMS

A Medicare claim is submitted as previously explained; however, when you submit the claim, be sure you also submit the Explanation of Benefits (EOB) which you receive from Medicare. The Claims Administrator may be unable to accurately determine benefits payable under the Plan without the Medicare EOB.

DENTAL CLAIMS

Discuss the treatment plan with your Dentist. If the services will exceed \$500, ask your Dentist to submit a "Pre-Treatment Estimate." The Claims Administrator will advise your Dentist of the amount the Plan can pay toward your treatment.

If the services are for emergency treatment or less than \$500, a treatment plan is not required. Your Dentist only needs to complete his portion of the claim form.

WHERE TO SUBMIT A CLAIM

Completed claim forms and itemized bills should be submitted to the address indicated on your Health Benefit I.D. Card or at the following address:

Medical Claims:

Consociate/HL
P.O. Box 419104
St. Louis, MO 63141-9104
Payor ID #90001

Non-Medical Claims:

Consociate, Inc.
P.O. Box 1068
Decatur, IL 62525-1068
Payor ID #37135

ALWAYS RETAIN A COPY FOR YOUR RECORDS.

TIMELY SUBMISSION OF CLAIMS

All charges must be submitted within twelve (12) months after the date incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.

Initial Claims

Benefits are based on the Plan's provisions at the time charges were incurred. The Claims Administrator will review the initial claim to determine if sufficient information has been submitted to enable proper consideration of the claim. A claim decision will be made (in most cases) no later than:

1. 72 hours for urgent care claims;
2. 15 days for pre-service claims;
3. 30 days for post service claims;
4. 45 days for disability claims.

If, because of extenuating circumstances, proper notice and delay is beyond the Plan's control, a fifteen day extension will be allowed for pre-service and post service claims.

Failure to Follow Procedures

If the claim submitted does not follow the proper procedures as set forth in the Summary Plan Description the Claims Administrator will notify the Covered Person no later than:

1. 24 hours for urgent care claims;
2. 5 days for pre-service claims;

Request for Missing Information

If the initial claim submission does not include sufficient information required for processing, the Claims Administrator will request additional information from the Covered Person no later than:

1. 24 hours for urgent care claims;
2. 15 days for pre-service claims;
3. 30 days for post service claims;
4. 45 days for disability claims.

Provide Missing Information

A Covered Person will be required to submit the requested information to the Claims Administrator no later than:

1. 48 hours for urgent care claims;
2. 45 days for pre-service claims;
3. 90 days for post service claims;
4. 45 days for disability claims.

CLAIMS REVIEW PROCEDURE

Appealed or Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the Covered Person may appeal the denial. This appeal provision will allow the Covered Person to:

1. Request from the Claims Administrator a review of any claim for benefits. Such request must include: the name of the employee, his Social Security number, the name of the patient and the Group Identification Number, if any.
2. File the request for review in writing, stating in clear and concise terms the reason or reasons for disagreement with the handling of the claim.

Claimant to Request Appeal

The request for review must be directed to the Claims Administrator within one hundred eighty (180) days after the claim payment date or the date of the notification of denial of benefits.

Determination of Appeal

A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the Covered Person with a written response not later than:

1. 72 hours for urgent care claims;
2. 30 days for pre-service claims;
3. 60 days for post service claims;
4. 45 days for disability claims

after the date the Claims Administrator receives the Covered Person's written request for review.

Fair Process

If a treating physician determines the claim is “urgent”, the plan will treat the claim as urgent. The Plan will not impose fees or costs as a condition to filing or appealing a claim.

Arbitration will be permitted, but only with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if the claimant agrees after completion of an internal review.

The review will be *de novo* (anew).

The decision maker on the appealed claim will be a different person than the person making the initial claim decision.

The Plan will consult with appropriate health care professionals in deciding appealed claims involving medical judgment.

Covered Person must exhaust the claims appeal procedure before filing a suit for benefits. No legal action shall be brought to recover under the Plan unless commenced within three (3) years after the expiration of the time within which proof of claim is required to be filed by the provisions hereof; but if any time limitations of the Plan with respect to bringing any legal action is less than that permitted by the law of the state in which the Plan is delivered, such limitation is hereby modified to agree with the minimum period permitted by such law.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Jackson County Government Group Health Benefit Plan is the benefit plan of **Jackson County Government**, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by **Jackson County Government** to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, **Jackson County Government** shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Covered Person's rights,
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required.
8. To establish and communicate procedures to determine whether a medical child support order is qualified.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the Plan documents.

THE NAMED FIDUCIARY

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee, Retiree or Dependent:

A copy of the Trust agreement.

A complete list of employers and employee organizations sponsoring the plan. Service of legal process may be made upon a Plan trustee.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

HEADINGS

The headings and subheadings of this Plan Document and Summary Plan Description have been inserted for convenience of reference and are to be ignored in any construction of the provisions thereof,

CONFORMITY WITH LAW

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements thereof. This Plan intends to comply with any laws to which it is subject, whether or not this Plan has been specifically amended accordingly. These laws include TEFRA, DEFRA, COBRA, The Family and Medical Leave Act of 1993 (FMLA), Budget Reconciliation Acts, HIPAA, MHPA, MNHPA, WHCRA, and any other laws which may have been enacted already or which may be enacted in the future.

LIABILITY OF OFFICERS AND EMPLOYEES

No officer or Employee of the Employer who may or may not be acting in a fiduciary capacity shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with his duties in connection with the Plan, except in cases of wanton or willful negligence, or willful misconduct. Such officers or Employees shall be indemnified and saved harmless by the Employer from and against any liability to which any of them may be subjected by reason of any such good faith act or conduct in their official capacity, or by reason of conduct consistent with such prudent man rule acting in such fiduciary capacity, including all expenses reasonably incurred in their defense to the extent permitted by law.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the overpayment.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

PRIVACY AND PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the Human Resources Manager.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Human Resources Department. If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact:

Privacy Officer
Jackson County Government
Jackson County Board Office
1001 Walnut Street
Murphysboro, IL 62966
(618) 687-7240

HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

“Electronic Protected Health Information” (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

“Security Incidents” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.
2. Notify the media if the breach affecting more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded plan and the administration is provided through a third party Claims Administrator. The Plan is not insured. Benefits are paid directly from the Plan through the Claims Administrator.

Plan contributions for Employee and Dependent coverage are made by the Company and Employee.

PLAN NAME Jackson County Government Health Benefit Plan

PLAN NUMBER 501 **TAX ID NUMBER** 37-6001102

PLAN AMENDED AND RESTATED December 1, 2012

PLAN YEAR ENDS November 30th

EMPLOYER INFORMATION

Jackson County Government
Jackson County Board Office
1001 Walnut Street
Murphysboro, IL 62966
(618) 687-7240

PLAN ADMINISTRATOR

Jackson County Government
Jackson County Board Office
1001 Walnut Street
Murphysboro, IL 62966
(618) 687-7240

NAMED FIDUCIARY

Jackson County Government
Jackson County Board Office
1001 Walnut Street
Murphysboro, IL 62966
(618) 687-7240

AGENT FOR SERVICE OF LEGAL PROCESS

Jackson County Government
Jackson County Board Office
1001 Walnut Street
Murphysboro, IL 62966
(618) 687-7240

CLAIMS ADMINISTRATOR

Consociate, Inc.
2828 N. Monroe
P.O. Box 1068
Decatur, IL 62525-1068
(217) 423-7788
(800) 798-2422

UTILIZATION REVIEW SERVICE

Ault International Management LLC
(877) 269-6877 (Inside Service Area)

NOTICE

The Plan Administrator believes the Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the contact information listed in the General Plan Information Section. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

**ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY
PLAN DESCRIPTION**

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Jackson County Government (the "Company" or the "Plan Sponsor") as of December 1, 2012, hereby **amends and restates** the Jackson County Government Employee Group Health Benefit Plan (the "Plan"), which was previously adopted by the Company.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Jackson County Government

By: _____

Name: _____

Date: _____

Title: _____